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ARCHIVES OF SURGERY.

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ARCHIVES OF SURGERY.

BY

JONATHAN HUTCHINSON, LL.D., F.R.S.,

*Consulting Surgeon to the London Hospital, and late President of the
Royal College of Surgeons.*

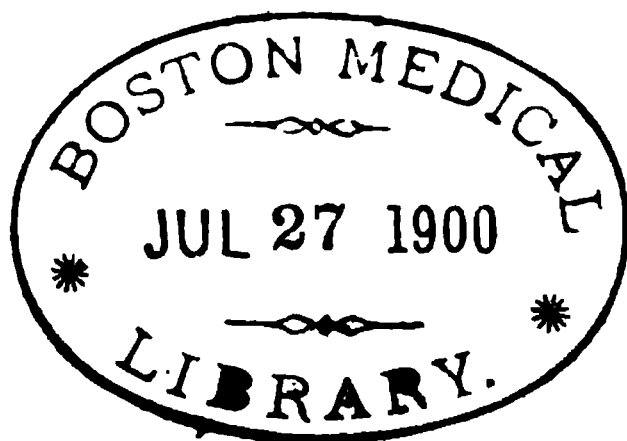
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- CXXXVIII. FLUTING OF THE NAILS, BEGINNING AT THE LUNULA.
- CLX. FRAMBÆSIA IN AN ENGLISHMAN.
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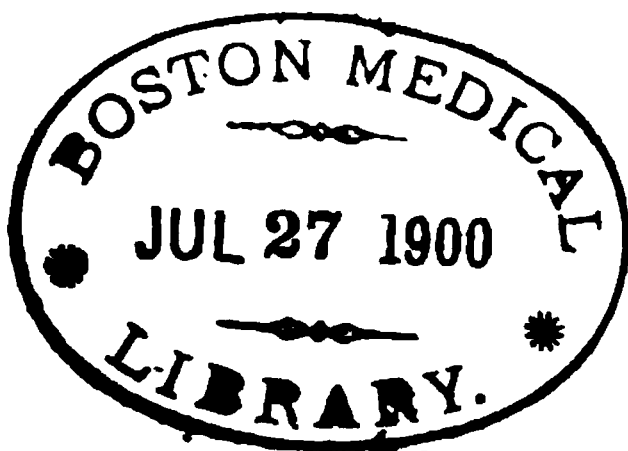
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ARCHIVES OF SURGERY.

JANUARY, 1899.

CHALKY URINE AND THE PHOSPHATIC DIATHESIS.

THE "phosphatic diathesis" is, I believe, now usually treated as a myth. In his able work on urinary diseases, I find that Sir William Roberts thus refers to it: "Dr. Prout dignified with the name of 'phosphatic diathesis' the tendency to the deposition of earthy phosphates in the urine. Dr. Bence Jones has, however, clearly shown that this designation is wholly inappropriate. There is not the least reason to believe that there is any constitutional state specially characterised by an excessive excretion of phosphates; the phosphatic diathesis of Prout is simply ammoniacal urine."

With the greatest possible respect for the opinions of such observers as Roberts and Bence Jones, I still believe that Prout was right, and that there is a special condition of health, of which the most prominent symptom is the appearance of phosphate of lime in the urine. In slight forms this condition of health is, I think, not very uncommon; and it is attended by dyspepsia, nervousness, and backache—just the group of symptoms which Prout described.

The condition is one which, in severe forms, I have found extremely difficult to treat, whether by diet or drugs. It seems to be, indeed, almost incurable. It is not specially associated with sex-exhaustion, though it is to be admitted

that nearly all its subjects are males. Nor is it always in connection with excessive mental strain.

Although Sir William Roberts discredits altogether the existence of a phosphatic diathesis, he has recorded one case which is, for me, a good example of it in a mild form. I will reproduce this case, with its distinguished author's comments, before proceeding to the narration of my own.

*Copious Deposit of Triple Phosphate in Fresh Urine and
in association with Neurasthenia.*

“ In the immense majority of cases the deposition of this salt is only an incident due to the loss of the acid reaction of the urine, and especially of ammoniacal decomposition of the urine. Occasionally, however, it occurs in fresh urine, which is neither decomposed nor sensibly (to the smell) ammoniacal. The following is the most remarkable instance which I have witnessed :—J. P., a gentleman, aged 29, of a moderately healthy appearance, but irritable temperament, consulted me on account of a sense of weakness in the back and loins, with general debility and languor, and a tendency to sudden perspirations and fits of nervousness. There was a severe smarting at the close of micturition. He had suffered from gonorrhœa three years previously, but had been completely free from any urethral discharge for some time. The urine was examined on several occasions. It was faintly acid when voided ; and deposited, sometimes before it was cold, and generally within a couple of hours, an abundant precipitate of the unmixed ammoniaco-magnesian phosphate. The annexed note was taken of the urine voided at 11.30 a.m. on January 28, 1861 : ‘ In half an hour it was found transparent, perfectly sweet (*i.e.*, not putrescent), faintly acid ; and sparkling crystals of the triple phosphate could be seen floating in it. At 4 p.m. the same day the specimen was quite clear ; brilliant crystals of triple phosphate studded the sides of the glass ; and at the bottom was collected an abundant snow-white deposit of the same crystals. The urine was not albuminous, neither did it contain pus or epithelium. On the following day the specimen continued unchanged ; but on the fourth day the reaction had become faintly alkaline : the deposit was losing its snow-white character, and reddish flakes, composed of spheres of urate of ammonia, had become deposited. From this date the urine began to decompose, and speedily became ammoniacal and offensive.’ This condition of the urine, together with the unpleasant symptoms before noted, gradually disappeared in the course of six weeks, under the influence of cold sponging, systematic exercise in the open air, and the administration of dilute nitric acid in a bitter infusion.”

It will be noted in the case just quoted that the salt present was the triple phosphate (ammoniaco-magnesian). It would appear that the “ white sand ” may be composed of any

one of three: the amorphous phosphate of lime, the stellar phosphate of lime, or the ammoniaco-magnesian phosphate, and that these are indistinguishable by the naked eye. The amorphous salt is, I believe, by far the more common. Both the two salts of lime are present in their full quantity when the urine is passed, and do not increase when it cools. Neither does the triple phosphate increase on cooling, but it may rapidly do so when decomposition sets in.

I have been told by my medical friends that phosphates as a deposit imply no more than that the urine is alkaline or neutral. There is no doubt that a neutral condition does usually attend them, and their more frequent presence in the *urina cibi* than in the *urina somni* is to some extent to be thus explained. In cases, however, such as those which I have to adduce, there would remain the question why in some persons there should be an almost lifelong tendency to alkaline urine, and what such tendency implies. We should but have altered the terms of our problem, for the facts would remain the same, and would still denote some constitutional peculiarity as revealed by the symptom. Nor can I believe that mere alkalinity, or, what is more usual, neutrality, would account for the enormous quantities of white sand which are present in some of these cases. These quantities are often such as to imply, I think, absolute excess of the salt, and I only regret that I have not by analysis put this matter to proof. Such proof would not, however, much affect the clinical significance of my cases.

Not only is it not true that the urine in these cases is ammoniacal, but it is certain that it shows often no special tendency to become so. I produced at one of my recent Demonstrations a specimen of phosphatic urine with abundant deposit which at the end of a week was still perfectly sweet.

On the other hand it may be urged by surgical critics that in truth these phosphatic deposits are due to disease of the mucous membrane of the urinary passages. Such, I feel certain, is not the case. The fact that the deposit is usually only occasional, and that in its intervals the urine is bright and

clear, seems conclusive on this point. In the early stages of these cases there is, besides, no irritability of the bladder, nor are pus or mucus cells to be found in the urine. In later stages some degree of cystitis may be present, but it is, I believe, caused by the long persisting condition of the urine. Patients always complain that the passage of white urine causes some discomfort and smarting, and that the sensation of desire to micturate often persists after the bladder has been emptied. It seems probable, therefore, that phosphatic urine is more or less irritating. Although in some of the cases there was a history of antecedent gonorrhœa, yet in none did it appear that cystitis had been caused by it, and in several of the best marked such history was absent. I feel sure, therefore, that the deposit of phosphates in these cases depends upon the patient's state of health and digestion, and not upon local conditions. Seeing that it may persist for many years, and is, indeed, part of the patient's constitution, it has as much claim to be considered a DIATHESIS as has the state which produces gout, or that which is denoted by the excretion of uric acid.

CASE I.—Amorphous Phosphates constantly present in the Urine during three years—Aching in the back on exercise and increase of the deposit—No history of Gout.

Mr. C. P. W.—, aged 30, consulted me on June 5, 1886. For nearly three years he had noticed his urine to be like "chalk and water." This was its constant condition, but it was more noticeable after exercise. Exercise always caused aching in the back, across the lower part of the lumbar region.

Mr. W—— had been living for some years in the tropics, but in a very healthy and elevated location. It was there that he had first noticed the white urine. He had lived well, taking much meat. He was also fond of sugar and tea. As a stimulant he had taken chiefly whisky, but a little beer. He had been living as a married man. Micturition when the urine contained much deposit was usually

attended by scalding. He had of late gained in flesh, but had lost colour.

Mr. W—— passed urine in my room. It was alkaline, thick and white. All the white deposit was dissolved immediately by acid. When allowed to dry on a glass, it left a white powder like chalk. The deposit under the microscope was amorphous.

No history of gout was known in the family.

CASE II.—*Phosphate of Lime present in stellar crystals (stellar phosphates) with Spermatozoa—Gouty tendencies—Weak knees, irritable eyes, and nocturnal emissions.*

Mr. G. M. H——, aged 21, of the Royal Engineers, consulted me on July 11, 1886. He looked exceedingly well, being ruddy and very brown from exposure to sun. He came because his knees swelled and were weak. I had seen him some years before on account of a swollen lip. His grandfather had suffered from gout. He told me that a brother of his, a surgeon, had said that he was “passing phosphates.” In addition to his knee-joint weakness he was liable to irritable eyes, and both these ailments were, he said, made worse if he took wine. He had been obliged to abstain from both beer and wine, as he felt worse directly if he took either. He had not the least irritability of the bladder. He had nocturnal emissions occasionally, and always “felt weak and flabby after them.” His knees were scarcely swollen, but he complained much of their weakness, and said that he could not stand long without pain. They varied on different days, and one day in a week or so would appear to be quite well. His bowels were costive.

I at once desired him to pass water. It was well coloured, of feeble acidity, and contained from the first flocculi in white clouds, which soon settled to the lowest part of the glass and looked like very thin gruel. I noticed at the first that the urine drew out in transparent strings, very thin, like mucus. It was not in the least ropy, and these strings were perfectly clear, like those of saliva, but more tenacious. I did not use the microscope till forty-eight hours later, and

then found phosphate of lime in beautiful rosette crystals (see Fig. 5 Beale, Plate 55, and Roberts, page 98).^{*} These crystals were all arranged about a central eye like the petals of a loose composite flower. A few spermatozoa were also present, and a few small "envelope-crystals" of oxalate of lime. The spermatozoa were very few, and were probably due to an emission which had occurred during the previous night. The urine formed only a very thin film on standing. On boiling, the clear supernatant fluid became opaque, but cleared again with acid.

CASE III.—*Phosphatic Urine during thirty years in a man otherwise in good health—Triple Phosphate deposit—Gradual increase of symptoms of Cystitis—Death from Cancer of the Stomach.*

My next case is one of the most severe and protracted which has come under my observation. Its subject was a man aged 47 in 1882, when he was sent to me by Mr. Greasley, of Canterbury, with a very full account of his symptoms. Partly from Mr. Greasley's notes, and partly from my own, I construct the following narrative. The prominent symptom for which I was consulted was the presence of white sand in the urine with considerable bladder irritation. The white sand was usually and chiefly the triple phosphate. Small quantities of mucus and pus were occasionally present, and later on, as will be seen, streaks of blood were observed. Thus the evidence of cystitis was much greater than in my other cases, but it must be remembered that these had supervened only after the white sand had been present for sixteen years.

Mr. W—— was of a gouty family, his father having suffered definite attacks. He remembered that as a boy he had an irritable bladder, and used to pass water more frequently than others did. Both he and his brothers were liable to lumbago. In early manhood he had a protracted

^{*} This deposit was first described by Dr. Hassell. See Sir W. Roberts' work, page 98. It is considered to be "a rare deposit," and when in quantity to be "usually associated with some grave disorder." It has been met with in phthisis, diabetes, cancer, and chronic rheumatism.

gonorrhœa, and some gonorrhœal rheumatism, but both in the end completely ceased. From twenty to thirty he was much at sea, and used to live freely and drink bottled beer. At this time he enjoyed capital health, but was often annoyed by observing that his urine stained the utensil and caused a disagreeable smell.

It was not, however, till about sixteen years before I saw him, when he would be thirty-one years of age, that his symptoms began to give him real trouble. From that date onwards white sand in varying quantities had been almost constantly present, and he had suffered more or less from lumbar pain. He had had much advice, and had been put under various plans of regimen, but without any definite advantage. His general health had, in spite of the state of urine, remained fairly good. Mr. Greasley, at the time he sent Mr. W—— to me, reported that the urine had a specific gravity of 1021, that it showed no albumen or sugar, and did not easily become ammoniacal. It often, however, showed white sand suspended in mucus in very large quantities. It had the odour of whey, and was usually neutral or alkaline. Two years before I saw him Mr. W—— had consulted Sir Henry Thompson, who found no stone, and ordered *tritium repens* with benzoic acid. He could take exercise without discomfort, and was accustomed to walk and to dig in his garden freely. He had not experienced any failure of nerve power, but was liable to great coldness of the limbs, with tingling sometimes in one limb and sometimes in another. Latterly he had been anxious as to his sight failing, but on use of the ophthalmoscope I could detect no disease.

As long as seventeen years ago, just before his marriage and when he was leaving the sea, he consulted the late Dr. Basham, not on account of his health, which was good, but solely about the state of his urine, which was offensive to the smell. Dr. B. allowed him to continue his beer, but advised the systematic use of alkalies. Subsequently others had prescribed acids, and enjoined total abstinence from stimulants. He had abstained from beer for a whole year, but without any benefit to his troublesome symptom. He

had been, when I saw him, sixteen years married, and had three healthy children. There was no reason to suppose that his symptom had anything to do with his sexual system.

He had observed that bitter beer and sherry always made the bladder more irritable, but that stout had no such effect. He had not as a rule found that he was made worse by occasional indulgence at table.

He had observed that the white sand did not usually come down with the first morning urine, but it would often be present before breakfast if he again passed water. If he rose in the night the urine was usually quite clear. For many years he had observed white sand only, but of late there had been mucus also, and during the last six months he had several times observed little streaks of blood. The blood never stained the urine, but remained as a streak on a cohering mass of sand and mucus. The sand was always heavy, and fell to the bottom of the utensil at once.

My first measure was to use a sound, and ascertain that no stone could be found in the bladder. There did not appear to be much reason for suspecting calculus in the kidney, for there was no material backache, nor ever had been. The patient could take exercise without discomfort, and what he described as attacks of lumbago appeared to have been really such. I advised abstinence from alcohol, and prescribed nitric acid in twenty-minim doses. No benefit resulted from the acid; indeed the patient thought it disagreed with his system and increased the irritability of his bladder.

In October I requested a consultation with my colleague, the late Dr. Ralfe. Dr. Ralfe made a careful examination of the urine, and reported that it showed no evidence of bladder- or kidney-disease beyond the presence of a little pus. He noted an excess of urea, and a high degree of alkalinity. After this consultation the patient passed under the care of Dr. Ralfe, and I lost sight of him for some years.

Three years later Mr. W—— called on me again. He was still passing very large quantities of phosphates, but had almost lost his irritability of bladder. He had, however,

suffered much from dyspepsia and pain in the abdomen. He had lost flesh, and become gaunt and pale. He was liable to attacks of watery diarrhoea. He had, he said, formerly found citrate of magnesia very useful in relieving his pain, but it no longer did so.

After this I never saw Mr. W—— again, but Mr. Greasley has been good enough to reply to my inquiry to inform me that his patient died about a year later, with all the symptoms of cancer of the pylorus. A hard mass could be distinctly felt, and there was great emaciation. Unfortunately there was no autopsy. The irritability of the bladder had during the last year almost disappeared, but I have no definite information as to the state of the urine.

It has been noticed by several observers that patients who pass stellar phosphates are apt to develop cancer. In this instance, however, the stellar crystals were never found.

CASE IV.—*Dyspepsia, Nervousness, and Phosphatic Urine.*

A gentleman consulted me on account of peculiar nervous symptoms. He told me that he had had a good deal of trouble in his family, and that it had made him so nervous that he could scarcely do anything, excepting in his business. When in his counting-house he said that he usually felt tolerably well, but in the street, at home, and when visiting, he was distressingly nervous. He said that his nervousness sometimes took the form of an inability to will to do anything, and he became quite unable to make any attempt to move. He assured me that he had sat on a seat at a suburban railway platform, and let five or six trains go past without being able to rise to get into the carriage; and he said that in the street he would sometimes hail an omnibus and then be quite unable to make himself move towards it. In the night he annoyed his wife by constantly starting in his sleep. Although he looked well he complained much of feeling weary. He also mentioned as an especially annoying symptom that his upper eyelids in the morning always felt stiff and heavy, and that he did not get rid of this symptom until he had had his lunch. He had no positive headache, but distressing feelings

in his head. He had during the last year or two lost the sight in his right eye. I could find no ophthalmoscopic changes, but he assured me that in boyhood, being a great reader, and often making his eyes ache, he had been accustomed to read first with one eye and then with the other. He was, therefore, quite sure that he could at that time see as well with the right as the left. At the present time he could only puzzle out No. 20. About a year ago he had been under Sir William Bowman for this loss of sight in his right eye, and he said that Sir William, like myself, had been unable to find any definite cause. It will be seen that his symptoms might most of them have been classed as "male hysteria," but I doubt whether they were exactly of that nature. Finding that he had been very dyspeptic, I asked whether he had ever passed white urine, and he told me "Yes; sometimes at the end of micturition it is white like milk." Claret was the only wine that he could drink. Champagne invariably irritated the kidneys, and produced white urine. He told me that he had consulted me three years previously, and on referring to my notes of July 2, 1884, I found a record of the following points which are of some interest with reference to the influence of drugs and articles of diet. He was very susceptible to the influence of the iodide of potassium. He had suffered from rheumatism and rheumatic gout, and was liable two or three times a month to what he called "general stiffness." His father had had true gout, and had often been to Carlsbad for it. Champagne, sherry, and brandy always had the effect of making him feverish and of causing white urine. Champagne in particular would create intense thirst, attended with backache, and desire to pass water very frequently. The whiteness in the urine always appeared at the end of the act. Red wines, he thought, suited him well. A cup of strong tea taken in the morning would destroy all his energy for the day. Formerly he had been able to sleep well after tea or coffee, but of late he could not sleep at all if he took either of them in the afternoon. Coffee always left the taste in his mouth for hours afterwards. His father was, he said, a strong, vigorous man, but his mother was

exceedingly nervous. He appeared to inherit his father's gout and his mother's nervousness. In early life he had been liable to faint.

We have in this case an example of a very mobile state of the nervous system, associated with much loss of tone, but with no failure of general nutrition. The symptoms were increasing as life advanced, though with great variations. The most prominent objective symptom was the appearance of white sand in connection with attacks of dyspepsia, and as the prompt result of taking certain wines. As his father had had gout, and he himself was liable to "rheumatic stiffness," it is probable that his state of digestion was not far removed from that which favours lithiasis.

It will be conjectured that the sexual system had something to say to the extraordinary state of nervous susceptibility which I have described. No doubt such was the fact. Mr. M—— had in early life been liberal as regards intercourse, and had had gonorrhœa three times and primary sores no fewer than three. He was twenty-seven when I first saw him, and had been married two years. When he came to me in 1887 (four years later) he considered that his health was injured by his wife having refused to permit intercourse. Sexual excitement without intercourse, he thought, always made him nervous. Some doubt may be felt as to whether he was altogether right in his impressions.

CASE V.—*White Urine occurring intermittently during more than a year.*

The following case (the last I have seen) may serve as a good one from which to study the phenomena of this diathesis. In a former number of ARCHIVES (see Vol. VII., p. 190) I endeavoured to draw attention to the peculiar symptom of white splashes on the boots left where drops of urine had fallen, as one which patients now and then observe for themselves. It was present in this instance, and the patient referred to it in the outset of our consultation. He had come to me solely on account of the condition of his urine.

It frequently, as he said, contained a white sediment, and if any dropped on his boots it left a white splash. He was otherwise a healthy man. He had no indications of cystitis, and no irritability of bladder. When the phosphates were present, he said, micturition always left an uncomfortable sensation in the urethra as if the bladder were not quite relieved; but he did not make water more frequently than other people, nor did he ever rise in the night to do so. The phosphates were not always present, and when not so the urine was as clear and bright as water. He brought me two specimens, one with an abundant white sediment and looking semi-opaque like thin whey, the other perfectly clear. He passed water in my room, and I found it quite clear, though of neutral reaction. It had a specific gravity of only 1005.

Mr. W—— could give me no clue to the cause of his affection. He did not connect it with any special article of diet. It appeared certain that he had never suffered from inflammation of the bladder. He was a married man, aged 36, and although in early life he had had a gonorrhœa, it was, he said, a very slight one and soon well. The intermittent occurrence of the phosphates also appeared to show conclusively that they did not depend in any way upon disease of the mucous membrane of bladder or kidney. The urine voided first thing in the morning was always clear, that in midday often contained phosphates, and that in the late evening was again usually clear. Often, however, for a week together there would be no deposit. When the phosphates were present there was usually some discomfort in the back, and he felt a certain degree of lassitude. Mr. W—— was accustomed to take tea to his breakfast, beer to his lunch, tea in the afternoon, and spirits, wine, or beer again at his late dinner. He was a temperate man. There did not appear to have been any excess in sexual intercourse, but he admitted having taken “precautions.”

When the phosphates had made their appearance, they would usually recur in midday every day for three or four days and then cease, and after a week's absence return again. He had been liable to these attacks for a year or

more, and they were increasing in frequency. A long conference failed to elicit anything explanatory of this peculiar symptom. The digestion appeared to be good, there had been no business anxiety, and the patient was on the whole in good health. Sixteen years ago I had treated him for syphilis, but he had had no symptoms since.

The salt which caused the white deposit in this instance was the amorphous phosphate of lime. With the exception of a few very small envelope-crystals of oxalate, nothing of a crystalline character could be found.

I had for examination two specimens, one in a bottle brought me by the patient, already a day or two old and containing an abundant white deposit, the other voided in my room and perfectly clear. Neither of them showed any special tendency to decompose. Three days later both were quite free from odour. The recent specimen, which had stood in an open test-tube, had become a little cloudy, and showed a thin iridescent film on its surface. It contained some very fine amorphous phosphate and crowds of bacteria. The other specimen, two days older but in a corked bottle, showed no bacteria.*

CASE VI.—*Amorphous Phosphates with Alkalinity in a Case of Eczema.*

In the case of Mr. G. E. S——, a man of forty, who was under my care for eczema and who inherited gout, the urine was opaque, alkaline, and phosphatic. He was married, and somewhat neurasthenic. The condition had been present some months. The following is my note as to the state of the urine: Urine quite opaque and milky when voided; feebly alkaline, and depositing immediately white sediment. It remained fresh and of good odour more than twenty-four hours, and the supernatant fluid after the phosphates had fallen was bright and clear. On standing, an iridescent film formed on the surface. No crystals could

* Sir W. Roberts has written, "The turbidity caused by the amorphous phosphate exists at its greatest intensity at the moment of emission, and does not increase on cooling." This I can quite confirm.

be found, either in the film or the deposit, the latter consisting of amorphous phosphates.

Brief mention of Five Cases in Early Stages.

In Vol. VIII., at page 189, I have recorded the fact that in four cases the symptom of white splashes on the boots had been mentioned to me by patients. In all these the occurrence had been only occasional, and in none had I had any opportunity for examining the urine. In all the patients averred that the occurrence was usually observed during journeys. In none of these were there any indications of cystitis or of renal disease. All the patients were men, and in most there was a history of inheritance of gout. My friend Mr. Cadge, of Norwich, has mentioned to me another similar case, of which one of his friends (I think a surgeon) was the subject. Whilst retaining good health, this gentleman had been during many years annoyed by occasionally seeing his boots splashed with white spots after making water.

I am not able to give any details of any of these five cases. They must probably be allowed to stand as examples of the phosphatic diathesis in a mild form. In some of them possibly it may have proved to be only an early stage, for in one at least of the more severe ones which I have recorded there had been a long period during which the history was much the same as in these. The influence of journeys in producing the deposit has been observed in almost all cases during the early stages, as also the fact that the urine of sleep scarcely ever shows it.

(To be concluded.)

NOTES ON SYMPTOMS.

(Continued from page 840.)

No. XLVIII.—On “*Numbness and Deadness*” as
distinct from Anæsthesia.

In ARCHIVES, Vol. VIII., p. 231, will be found the notice of a case in which a patient persistently complained of numbness and deadness in one half of his face, whilst there was no loss of common sensation. The expressions “numb” and “dead” must be carefully appreciated in different cases, or we shall often much mistake what our patients really mean. Although the use of these words in the case referred to, without their implying any degree of cutaneous anæsthesia, was noteworthy on account of the phenomenon having been carefully and repeatedly examined, it is not perhaps very rare. I have now two cases to relate which illustrate it.

A lady who seven years ago suffered from syphilis is now the subject of symptoms of commencing tabes. Her chief complaint is, however, of numbness of the right lower extremity and side of trunk. This numbness is greatest in the outer and back part of the thigh. Not only does it not imply loss of cutaneous sensation, but the latter might be thought to be increased. The sense of deadness is not a mere negation; it amounts to a disagreeable sort of ache, and its subject resorts to various artifices to get rid of it. Sometimes she moves the thigh about rapidly, and sometimes she gets her maid or her husband to beat or rub the part very roughly. Such measures relieve her for a time, but she complains that the deadness always returns. The seat of the sensation appears to be in the muscles, but there is no appreciable loss of muscular power.

My next case is a yet more definite one, and in it the lesion is no doubt cerebral, probably thrombotic, and the condition occurs as part of the phenomena of hemiplegia. Its subject is a man aged 34, who had syphilis five years ago. He was never very efficiently treated, and although he regained good health and led a life of some hardship in a colony, he was seldom for long together rid of a pustular scar-leaving eruption. Some of this eruption was still present, but he had taken no specific for six months, when he had attacks of "tingling" in the right side of face and right limbs. The tingling lasted only a few minutes, and occurred only two or three times. He went to bed feeling well and without the slightest trace of headache, but found on waking that the whole of right side, face and limbs, was numb and dead. There was also a general, but only slight, loss of muscular power, for he could not write, he walked dragging his leg, the side of his face was expressionless and puffed out when he attempted to whistle. It was thought that there was some drooping of the upper eyelid and that he spoke with some hesitancy, but there was no aphasia. The grip of his right hand was weaker than his left. He never kept his bed, and was always able to walk about the house, nor had he any bladder symptoms.

I did not see Mr. J—— until six weeks after the seizure described, but he brought with him a detailed description by his surgeon, from which the above statements are taken. When he came to me he had almost wholly recovered. The muscles of the affected limbs were of good size, and he could walk fairly well. His writing was still rather tremulous, and he complained that he could not write quickly or do any fine work with his right hand. He could whistle, but not well, and quite without his knowledge his right cheek puffed in the attempt to do so. He had also occasional spasms of his zygomatics of which also he was not conscious. The symptom of which he made most complaint was that his right limbs and side of face were "dead and numb." This dead sensation was, he said, constantly present and was attended by some slight perception of "pins and needles." On careful trial I could not discover any deficiency

in cutaneous sensation. As in the former case, it seemed probable the sensation was in the muscles rather than the skin. It was evidently a very disagreeable feeling, for he made great complaint of it.

As is well known, loss of sensation in the skin is often quite unattended by numbness. The patient does not know that his skin cannot feel until it is tested. This varies in different cases. It is, however, important to be able to translate the expressions which our patients use, and when deadness is the subject of complaint I suspect that the sensation denoted is much more often in the muscles than in the skin. It is a symptom which often persists for a long time, and sometimes after almost all trace of muscular weakness has disappeared. The degree of muscular weakness may be very inconsiderable. In the case formerly published the face was involved in "deadness," but one of the ocular muscles and the levator palati could be proved to be paralysed.

No. XLIX.—*On Exaggerated Pulsation of the Abdominal Aorta.*

Every practitioner is familiar with cases in which the abdominal aorta just below the epigastrium pulsates so vigorously that it is difficult to avoid the suspicion of aneurismal dilatation. We feel certain from our knowledge of other cases that there is no local disease of the artery, nothing which ought to be considered aneurismal, whether fusiform or sacculated, but yet the impression given to the fingers is such that we almost doubt the conclusions of clinical experience. Sometimes in thin patients the pulsation is even visible, and not unfrequently it becomes visible at once if the finger be placed upon the spot even with the very lightest pressure. Often there is lateral pulsation also, which is most deceptively like that of expansion. As the patients who exhibit this symptom never have any seriously aggressive disease, we never get opportunities for post-mortem estimation of the size of the aorta. Not improbably it is

often really enlarged by a general increase both in calibre and in thickness of coats (arterial hypertrophy with dilatation). In other cases it may be dilated without hypertrophy. The fact that the abnormal pulsation, although greatest at the epigastrium, is usually continued down the abdomen and implicates the iliacs and even the femorals, favours this suggestion. The symptom is, in my experience, not often met with in the young or in the aged. Its subjects are usually of middle age, and they may be of either sex. They are often distinctly neurotic, but in estimating this there is the fallacy that the state of the artery may perhaps be the cause of the neurosis. I have been consulted more than once by medical men who had been made anxious by this symptom in their own persons, and have had great difficulty in dispelling the suspicion of aneurism.

The case in which I have most recently studied this condition, and which has drawn my attention to it at the present time, is that of a lady who has been four years under my observation. She is now thirty-seven years of age. She is thin and very pale, and has never from childhood enjoyed robust health. When I first saw her on July 2, 1894, it was for a trivial eczema at the navel that she sought advice, but her principal complaint was of distressing sensations which she imagined were in connection with it. She continually spoke of her "navel troubles," but meant by that expression a sense of fulness and distension below the navel, which was at times enough to make her feel faint. In the examination which followed I was struck at once by the vigorous pulsation of her aorta. If the finger were placed on it with the slightest pressure it could easily be seen to be lifted with each stroke of the pulse. Miss C—— was thin and her abdomen empty, and her abdominal aorta and iliacs could be easily traced. They all pulsated with most abnormal force, and the same was the case with the femorals. The pulse at the wrist was soft and feeble. I have no doubt that there was considerable enlargement of all the abdominal arteries.

I saw Miss C—— again four years later, when I had quite forgotten her case. She again came for the eczema of her

navel, and again on examination my attention was at once drawn to the peculiar state of her aorta. On looking up my notes I found recorded what I have written above. It thus appears certain that the condition of things has remained during this period with but little alteration.

Through the whole of this time Miss C—— had been liable to so much discomfort in connection with her abdomen that she said she could not enjoy her life. Any little excitement would bring on an attack of pulsation attended by such a sense of distension that she often “felt all power leaving her,” and as if she must faint. On these occasions her only resource was the recumbent posture. She was habitually very pale, but on these occasions she believed that she became of a deathly pallor. She described a sensation as if she must lift something away under the navel. Imagining that the navel communicated with internal parts, she attached great importance to the slight eczematous irritation which still persisted there.

The following notes give some additional details of the case at the present date. I may add that it has an almost exact parallel in that of a young man who has been at times under my observation from childhood upwards.

The aorta, from just below the epigastrium downwards, pulsates so strongly that it is impossible not to suspect that it is both dilated and hypertrophied. The pulsation extends from side to side. It is felt as soon as the fingers touch the walls of the abdomen. The femorals are not now perceptibly enlarged, nor are, so far as can be ascertained, the external iliacs. She is very pale.

Any little shock causes pulsation under the navel, and she feels cold and faint. She is obliged to sit down, “as there is such a weight at the pit of the stomach if I continue standing.” When this feeling passes off she has shivering and headache, and usually goes to bed. She scarcely ever goes into public, as any excitement causes these attacks. If she stays quietly at home she does not have the attacks often—not more than once a fortnight, but she is often threatened with them.

There are sources of fallacy which it is necessary to guard against in estimating the symptom of abnormal aortic pulsation. The thinness of the walls of the abdomen and the emptiness of the viscera may easily leave the aorta unduly conspicuous. Curvature of the spine may also throw the vessels forward. In the case just described I could without causing pain take the spine between my finger and thumb, and at first I was inclined to think that there must be a curvature. None such was, however, appreciable in the erect position, but I could not resist the impression that the bodies of the vertebræ were much longer than usual from before backwards. This measurement does undoubtedly differ somewhat in different individuals. That this peculiarity, if present, did not, however, explain the whole was obvious, since the iliacs and femorals were at one time involved in the abnormal pulsation.

No. L.—*The Spontaneous Occurrence of Sensations resembling those of an Electric Shock.*

The sensation of tingling as known when a limb goes to sleep, and popularly recognised as “pins and needles,” is pleasurable rather than otherwise. There is, however, another sensation allied to it which is distinctly painful. An intelligent patient called it “all needles,” and said it was like the pricking produced by an electric shock. This sensation differs from the other also in its duration, for it is over in two seconds, whereas the pins and needles may last indefinitely. The pain of the electric shock is such that if it lasted it would make the sufferer cry out.

I have myself experienced this kind of pain very definitely. It occurred four or five times during one afternoon which was chiefly spent in a railway carriage. The tract affected was the outer side of the right foot from maleolus to toe and spreading upwards towards the dorsum. On each occasion the part was precisely the same and the sensation the same. It was as if twenty sharp needles were suddenly thrust in. On each occasion it occurred just after I had

moved the leg. It was over in a moment, but it produced exactly the same inclination to cry out which an electric shock produces. It occurred obviously in the territory of the small peroneal nerve, but there was no tenderness over the trunk of this nerve, nor had there been any preceding pressure. I was in good health and free from all evidences of gout. No numbness in the part resulted. To my astonishment, when, in the evening, I was comparing the sensibility of the two sides, I found that on the parallel region of the opposite foot the deep structures were definitely tender on pressure. On this side there had been no explosions. There was little or no tenderness in the foot which had been affected.

No. LI.—*Pitting of the Skin, especially marked on the Head, without Obvious Cause.*

Succulency of the subcutaneous tissue is the symptom which is illustrated by the case which I have to narrate. The patient complained to me that his hat always caused a ridge on his forehead, and said that he could make a "dent" in the skin with his finger. I found that he was correct, and that over all parts of the skull slight, but quite definite, pitting could be produced. He thought that it was his head only which showed this symptom, but, on trying, we ascertained that over his shin bones in both legs, and possibly also in slight degree on the backs of the hands, pitting could also be produced. Yet there was no obvious œdema or swelling anywhere. His feet did not swell at night, and he had never observed any ridge above his boot tops. He was, he considered, in good health, and although he was pale it could not be said that his face looked puffy. His urine was examined on three occasions and no albumen was found.

The fact that succulency was most marked on the head made it clear that the case was not one of œdema from vascular obstruction or over-fulness of veins. My impression is that the case should rank as one of exaggeration of a

normal condition. In most persons, though in very varying degrees in different ones, the skin can be indented by pressure sufficiently firm and sufficiently long continued. It must be remembered, however, that in this individual it was a new thing and had been noticed only for a few months.

The antecedents of the case were that its subject had suffered from syphilis ten years ago, for which he had had the usual mercurial treatment, and that he had within the last year taken iodide of potassium on account of two local nodes on his skull. These nodes had completely disappeared. The œdema was not restricted to their sites, but occurred equally on all parts of the head.

No. LII.—*The Sudden Occurrence of Phosphates in the Urine introductory to an Illness with Lung Symptoms and Dry Pleurisy (local).*

An artist, aged 38, an abstainer and married, consulted me with the statement that he had had an "attack of phosphates in the urine." It appeared that during the recent hot summer he had, whilst staying in Paris, suddenly fallen out of health and noticed that his urine was "white as milk." He consulted a physician in Paris, who told him that he was passing phosphates in great excess and advised him to live freely and to go home. At the same time he had much aching in the back just over the right kidney. He had never in his life before had any urinary trouble. After a while, a few weeks, the urine ceased to show the white deposit; but the pain in the right side, although less, persisted, and he became somewhat short of breath. He had a feeling as if something were obstructed in the lower part of the right lung. Some one whom he consulted advised the use of a chest dilator, and he thought he got benefit from it. Still the uncomfortable feeling did not leave him, and so on November 30th he came to me.

On December 30, 1898, I found the urine clear and acid. It became cloudy with earthy phosphates when boiled, but these dissolved with acid. I found dulness on percussion,

with a rough, dry friction sound over a considerable area below the right nipple, just where he complained of discomfort. In other parts of this lung and over the whole of the left respiration was free. He had no cough whatever, and had never expectorated anything. He had never had any attack of pleurisy or other acute chest ailment.

The facts as to his family history pointed in two directions. He told me that I had myself been once consulted by an uncle (æet. 54) of his, and on turning up my notes I found it was for a malignant growth in the abdomen. On the other hand, two of the patient's own sisters had died of phthisis. Although he was still going about and mixing in society he looked pale, and confessed that he did not feel well. He was still a rapid walker, but admitted that now and then he had been obliged to stand still in the street to get his breath. He had been in his usual health until September 8th, the date of his noticing that his urine was white.

No. LIII.—*On the Teeth in Inherited Syphilis.*

I have mentioned under the head of "Extracts from My Diary," at page 35, the case of a lad who was the subject of inherited syphilis and had an aneurism of one temporal artery. His case and that of his sister are also of great interest in reference to the value of deformed teeth as indications of inherited syphilis.

The teeth in this instance were a little peculiar. They were not in the least dwarfed, being of good width, and the notches, although marked out by deficiency of enamel, were not completed by breaking away of the dentine. The marks were, however, definitely crescentic, and there was no defect whatever of the lateral incisors. The lower incisors and the ten-year molars showed defects in their enamel suggestive of mercury in infancy. On inquiring as to the lad's family history, I learned that he had a sister two years older than himself and a brother three years younger. As his sister was in the waiting-room we had her brought before us. She had upper central incisors which showed large, broad

notches exactly like those of her brother, excepting that the notching was complete in hers whilst imperfect in his. All her other teeth were good excepting the ten-year molars. Her physiognomy showed nothing peculiar, and she had never suffered from keratitis or deafness. Respecting the younger brother, we were informed by Dr. Fletcher, who had brought the patients, that he had good health. No evidence as regards the parents or as regards the infancy of the patients was obtainable.

It will be seen from the above facts that the one sole indication of inherited taint in the girl was her notched teeth. It did not appear that she had ever had any special ailments. A sceptic as to the value of notched teeth as indicating syphilis might have fairly alleged that here was a case in which nothing corroborated the suspicion. This might have seemed a strong fact had the girl been seen alone ; but her brother had similar teeth, and he had passed through a severe attack of keratitis which had left its traces.

Having avowed my conviction that both sister and brother had really inherited the syphilitic poison, I drew attention to the fact that the elder of the two had apparently suffered the least. In reference to this, I said that a creed which I had formerly held that the eldest usually suffered most severely was, to some extent, an error. The eldest was the one most likely to suffer, but if one, two, or three in succession received the taint, there would be nothing which would make the taint likely to be more severe in one than another. By the side of this creed it is to be admitted that under the influence of circumstances which we cannot explain, syphilis, whether acquired or inherited, may vary in severity in different individuals within very wide limits indeed. Some children who inherit it probably never show any signs of it in infancy, and may very possibly escape also the keratitis, otitis, &c., which are not uncommon at adolescent periods. In the case before us, the girl had escaped everything excepting the notched teeth. It was yet to be seen, however, whether she would escape the keratitis, for this might occur for the first time as late as the age of forty,

or even later. It was, I said, by the occurrence of keratitis that the diagnosis, which at first might be held to be in some doubt, was not infrequently finally clenched.

No. LIV.—*On the insignificance of the Symptoms often attending Intra-Urethral Chancres.*

Many facts appear to indicate that intra-urethral chancres may be attended by very slight symptoms. Here are two.

Eighteen years ago I was consulted by a law student for a slight urethral discharge. It was not attended by the ordinary symptoms of gonorrhœa, and he now tells me that I examined carefully for a urethral chancre, but could never discover any local hardness. Under injection treatment the discharge ceased, no secondary symptoms were observed, and no mercury was given. Since then until the other day he has enjoyed good health, has married, and his wife has borne a healthy child. He now comes to me with acute phagedænic ulceration of the soft palate, which has destroyed the uvula, but is now arrested by iodide of potassium. I cannot doubt that it is due to remote syphilis, and my patient assures me that the occasion referred to is the only one on which he could possibly have contracted it.

My second case is that of a man of middle age, who on the same morning that I saw the subject of the above came to me with the question, "Have I got syphilis, or not?" He had a dusky papular eruption in his scalp and forehead, a scanty eruption of similar spots on his trunk, all his finger-nails were loosening by psoriasis of the nail-bed, and there were a number of mucous patches around his anus and in the cleft of buttocks. These symptoms had been present six weeks or more, and several surgeons had told him that they could be no other than syphilitic. With that opinion I entirely concurred. I assured him that there could not be the slightest doubt as to the diagnosis. "But," replied he, "I have never had a chancre." I examined his penis (he was circumcised), and could find no trace of one, nor did inquiry as to other regions elicit anything. "Have you had

a gonorrhœa?" I asked. "Well, yes, and no," he said. "I had four months ago a slight discharge, but it was without pain and got well of itself in a fortnight."

No. LV.—*On weakness of the Flexors of the Thighs.*

I have often asked attention to the fact that enforced rest of the lower limb after fracture of the patella or acute inflammation of the knee may lead to atrophy of the quadriceps extensor whilst the flexors remain in good condition. I have now to mention an instance, one perhaps of many, in which the converse condition occurs. Mr. H——, aged 69, is unable to use his flexors, the extensor remaining sound. The expression which he uses is: "I can kick well enough, but I cannot wipe my shoes." He can manage to walk, though in much fear of falling and with a constant sense of tightness in the ham-strings, but he cannot draw his legs backwards at the knee if there is any impediment in the way. He first came to me in October of last year complaining of this curious symptom, and he has called again this summer. On both occasions he has insisted that his "knees are stiff behind," but there is no evidence of this. All passive movements are easily permitted. He can use his quadriceps vigorously, but his flexors are feeble. The two limbs are alike. The condition entails an inability to walk far and a constant fear that he may fall. He has actually had one or two falls. He has no other symptoms of nervous disorder, but he is distinctly senile and has large arteries and a slow intermittent pulse. Three or four years ago he had an attack of "pins and needles" in his right leg which alarmed him, but it soon passed off. His vigour in walking has been failing for two years or more. His patellar reflex is good, possibly excessive, and his extremities maintain their warmth well. There is rheumatism and gout in his family, and as a boy he had rheumatic fever. He thinks that weather has some influence on his ability to walk, and adds that the sense of weakness is sometimes in his hips and sometimes

in his calves, but usually in the thighs. "I can put my feet forwards, but cannot get them back."

I suspect that the symptom I have described is due to the senile changes in the nervous system, and is not improbably a part of the shuffling, feeble gait which characterises old age. "Most weak hams" was one of the disabilities which Shakespeare thought it worth while to note, making, however, covert allusion to the sexual act rather than to any of the more ordinary uses of the limbs. It is, however, very possible that the two may in some way go together, and that the flexors of the thigh may, as a group, share with the glutei in senile decay. As I am not aware that any one has hitherto specially described the symptoms, it seemed worth a brief notice, more especially as it was the one for which, in this instance, the patient sought advice.

EXTRACTS FROM MY DIARY.

(Continued from page 294.)

On September 24th I went over to Clapton to see with my friend, Dr. Clarke, a very marked example of the crippling and anchylosing form of rheumatic arthritis. The patient was a woman, upwards of sixty, who had for some years been bedridden. She could not lie down, but sat up in bed with her back bowed forwards and knees bent. Both wrists and both ankles were quite stiff and apparently anchylosed. Both elbows and both knees were stiff, but not actually anchylosed. The hips and shoulders were much less affected and could still be moved. Nor were either of the joints of the lower jaw stiffened. In one forearm some movement in pronation and supination could be effected, whilst in the other limb it was quite lost. With this exception, the disease had crippled the corresponding joints of the upper and lower limbs in pairs and with remarkable bilateral symmetry. The digits were twisted and contracted, but not many of the smaller joints were actually anchylosed.

There was the usual history of true gout in the patient's family. Her father had suffered from it. She herself had never had gout, nor ever acute rheumatic fever. Her condition had begun in a prolonged attack of generalised arthritis which had followed exposure to night air in a cold fog. This was five and twenty years ago, and not long after a confinement. At first there had been much pain and swelling in the affected joints, but of late both these had abated. The poor woman was cheerful, and still enjoyed a fair condition of general health.

I believe that these cases of general crippling very seldom

occur without the history of true gout in ancestors, and never perhaps without its reality.

September 29, 1898.—I have just seen again Mr. P——, whose case, as an example of multiple keloid, is recorded in the *Edinburgh Medical Journal*. He has at the present time at least a dozen separate patches of keloid. Some of them are very large, others not bigger than shillings. I do not count a great number of pea-like nodules which have formed in the scars of suture-punctures after operations. One large keloid scar on his right shoulder is fringed with these little buttons.

His original keloids formed in vaccination-scars on his left arm. Others have developed in a scar left by excision of epidermis for transplantation, in three scars resulting from a dog-bite, in a scar on the knee from a cut received in a fall, and in the scars of boils. Almost every injury to the skin which he receives results in a nodule of keloid, and all the nodules spread. Meanwhile Mr. P—— appears to be in excellent health. It is now more than a year since I saw him, and we are both of us convinced that most of his keloids are now withering. The patches are less glossy, and less hard, and less thick than they formerly were; nor do they itch so much as they did. It is to be remarked that he has some scars about him which have never indurated in the slightest degree.

October 6, 1898.—I have just seen Mr. D——, a man from whose arm, six years ago, I excised what was diagnosed as a “fibro-sarcoma.” Unfortunately I have not preserved any details as to the microscopic examination. The scar—a rather large one, although the wound healed without suppuration—is now perfectly sound and white, and so also are those of the sutures. He comes to me now for a different matter. I remember his case well, and also that we were very anxious as to recurrence. He had had a “fibrous tumour,” which had been a year growing, cut out by another surgeon five months before my operation. The

whole line of scar from that operation had thickened like keloid, and near to it was a separate nodule as big as a large pea, very hard, but not in the least painful. This nodule did not look like keloid, and I did not diagnose it as such. Having regard to the very early recurrence, I advised an immediate and liberal excision of the whole scar, the nodule, and a good width of adjacent skin. This was done, with the result which has just been described.

The question may be raised, seeing that no recurrence has taken place, whether, after all, the original and the recurred growth were not of the nature of keloid. If so, however, it is remarkable that not the slightest induration of the scars has occurred. It is perhaps still more exceptional for keloid than for spindle-celled sarcoma not to recur after operation. The diagnosis at the time, based both upon naked-eye and microscope inspection, was sarcoma. Under either diagnosis the result is encouraging for free excisions. It is to be added that there is no history of tumours in the patient's family.

November 7, 1898.—I have this morning seen two of my old patients with rodent ulcer for whom the actual cautery had been used. In Miss B——'s case the disease was well advanced when I first saw her three years ago, and had formed a large ulcer close to the root of the left ala nasi. I used Pacquelin's cautery very freely. The result has been a sound scar, and no return until the last month. The spot for which she now comes is not so large as a pea, but quite characteristic. A three years' interval is very satisfactory.

In the second case the ulcer is on the tip of the nose and in a lady of 70. It is two years since the cautery, and the scar is sound with the exception of two little spots which have quite recently appeared. This patient has a withering scirrhus lump in one breast, and has lost a sister with cancer.

November 6, 1898.—The influence of local injuries—scratches and the like—in evoking the patches of Lichen

Planus has often been noticed. I have just seen a case in which it was well illustrated.

Mr. H——, aged 19, is a healthy young man, with no recognised proclivities. His eruption began in March last on the back of his neck and on the left arm near to two recent scars almost simultaneously. It has continued to spread ever since. It had itched at times. The eruption assumed different features on different parts. On the neck and upper part of shoulders and chest it consisted of small red lichenoid spots, which almost covered the whole surface (like Taylor's portrait). It ended abruptly above at the uncovered part of the neck. On other parts of the trunk the spots were discrete and of larger size, whilst on the forearms, especially near the wrists, there were large rough patches as big as half-crowns. These latter were irregular in shape, and many of them appeared to have been located by scratches and superficial cuts. In the palms of the hands there were crescentic and ringed patches of keratosis with peeling, partly caused, no doubt, by his occupation as engineer.

A gentleman whose case I have published as a marked example of Acromegaly, and who has kindly on several occasions attended at my Demonstrations, has just sent me a detailed statement of the measurements of his feet, extending from 1884 to 1898, and proving, as he thinks, that they are now decreasing in length. He retains good health, and his feet give him no trouble. The measurements show that in 1884 his right foot was $9\frac{1}{8}$ inches, and the left one $9\frac{1}{2}$. In 1887 the right was $10\frac{3}{8}$, and the left 10. In 1896 the right was $10\frac{7}{8}$, and the left $10\frac{3}{4}$; whilst in 1898 the right was only $10\frac{5}{8}$, and the left only $10\frac{1}{2}$.

I quote only a few of the more marked measurements, but their accuracy was borne out by numerous repetitions, sometimes as many as four in a year. Up to 1896 the increase was steadily progressive. The feet were measured usually twice a year, and in one instance four times. It is Mr. G——'s strong impression that during the last two years his

feet have diminished even more than the records and measurements would appear to prove.

October 11, 1898.—A gentleman whom I saw four years ago had then such large hands that I suspected Acromegaly. He assured me, however, that they had been large from boyhood, and that at school they had been called “leg of mutton hands.” When he came to me recently I was not particularly struck with the size of his hands, and should not have noticed them had I not read my former record. The illness for which he consulted me had on neither occasion anything to do with his hands. When I remarked to him that his hands did not strike me as being so large as they formerly were, he replied that he was sure that they were not, and that he could prove it by the fact that he now took smaller gloves. The explanation might in part be that with his advancing age his circulation had improved. Formerly his hands had been very liable to become mottled and dusky, and were no doubt slightly swollen when so. This liability had diminished with age and improved general vigour. He said that he still noticed that if he allowed his hands to hang down when walking his gloves became uncomfortably tight. The large dusky, mottled, and flabby hands of young people with feeble circulation are well known. It is not uncommon for the digits of aged persons to become very thin. A disappearance of subcutaneous cellular tissue and fat is a common occurrence with advancing years. Part of the hypertrophy of Acromegaly undoubtedly concerns the cellular tissue and the corium itself, and a diminution of this is an event quite possible. In saying this I do not wish to suggest that the case I have just mentioned was one of true Acromegaly, but merely to use it as an illustration of what may be possible in the latter.

October 12, 1898.—I visited at her home, in consultation with Dr. Burnet Smith, of Camden Square, an old lady who offered a good example of a certain type of “Erysipelas-Eczema.” I was told that she had just recovered from a

sharp attack of erysipelas of the head and face. It had now lapsed into a condition of exfoliative eczema. The general health had been quite restored, and the patient could take her meals and even go out of doors; but her face, ears, and scalp remained red, irritable, and covered with dry scales. It was now six weeks since the erysipelas. The latter, although attended by much œdema, had not been a very severe attack and had not spread lower than the neck. If any one should incline to doubt, however, whether it were not from the first acute eczema and not erysipelas, I may add that there was the history of a very severe and extensively spreading attack of erysipelas twenty years ago. Those who have once had erysipelas are well known to be liable to it again, and although the interval is long, I cannot feel much hesitation in regarding the recent attack as a repetition.

October 20, 1898.—The influence of season upon all lupus-affections has, if I mistake not, been remarkably evidenced during the summer which is just closing. The long continued heat has been most beneficial. I can speak for several chronic and partially cured cases which have been some years under my own observation that the improvement has in all been most definite. In one instance in which the scars left by lupus erythematosus, although sound, were still florid and fleshy, during the past autumn they have softened down and become pale.

I have long recognised that all observations on the remedial treatment of lupus are open to much fallacy if conducted in summer. All lupus-cases improve in summer and relapse in winter. In this fact their alliance with the chilblain type of inflammation is strongly suggested.

September 12, 1898.—The peculiarities of Mr. A. J——'s case are (1) that his eruption is very severe on his face, where it covers nose and cheeks in bat's-wings; (2) that the whole of the ears are involved in what looks like a dry eczema; (3) that many of the patches show peeling only, and not the slightest scale accumulation.

There can be no doubt that the eruption is essentially psoriasis vulgaris. It began when he was eight years old; he has in spite of it enjoyed excellent health ("never a day's illness"), but the eruption has persisted notwithstanding all sorts of treatment. On the elbows, and in long, broad streaks along the ulnæ, are very characteristic patches. For the rest the patches—some guttate and some large and irregular—are scattered over the chest, shoulders, and limbs, almost exempting the abdomen and thighs. His scalp is covered and the hair very thin. It involves the whole of the eyebrows, but has not caused them to fall.

October 20, 1898.—I saw Miss L——, in April of 1884, on account of aching eyes from hypermetropia, and ordered her glasses. The interesting point in her case was that there were present in each lens at its periphery a narrow rim of wedge-shaped opacities. Her teeth were good. Her neck was extensively scarred, as the result of scrofulous abscesses.

I did not see Miss L—— again for fourteen years, when I found that there had been no advance whatever in the lens opacities. She could still with her glasses see almost perfectly, and was accustomed to use her eyes very freely. Nor had any further manifestation of scrofula ever occurred.

During October, 1898, two children, the subjects of pruriginous urticaria and lichen, attended my Demonstrations. In both instances the child was in good health. Both had been before us on former occasions, and neither had made much improvement. In each instance there were now present groups of red erythematous papules, obviously quite recent flea-bites. In both, the mother told us that the child had been worse during the hot summer just passed.

In one of these, a Jew child, two years and a half old, the conditions, as I remarked, might fit well with a stage of "Hebra's prurigo," for the whole skin was covered with scratched lichen spots, and there were wide but enlarged glands in the groins and elsewhere. The question was,

however, would it prove incurable and be protracted into adult age? This, I explained, would depend upon the efficiency of the treatment. The measure of first importance was, however, one over which the medical adviser has but little power: the child ought to be sent to some home where no animals were kept, and where the exclusion of fleas could be secured. I averred my conviction that in both cases the eruption was really caused by fleas.

On October 19th, a young woman attended my Demonstrations who had a small tumour in connection with her right masseter. It was about an inch in front of the angle of jaw, as big as a large nut, rounded, and I thought fluctuating. Its peculiar feature was that it became prominent and tense (so as to be visible) when she clenched her jaws and almost disappeared when she opened her mouth. In the latter position it seemed that by pressure it could be emptied towards the mouth, but nothing could be felt from the inside. It was not in the least painful. When the jaws were firmly closed it was so tense and hard that it might have been supposed to be a bony outgrowth, but so soon as she relaxed the muscle it disappeared. I could not suggest any anatomical structure by which to explain this peculiarity. It seemed most likely that it was an hour-glass cyst—possibly cysticercus—one half of which was in the substance of the muscle.

Amongst the most interesting of the cases presented at my Clinical Demonstration on October 5, 1898, was a lad of sixteen with an aneurism of his temporal artery. The tumour was about as large as a hazel-nut, and pulsated freely. Its pulsations were stopped by pressure on the trunk below it. The skin over it was slightly reddened. It appeared that it had followed a blow from striking the head against a ladder. An interesting point in the case was that the lad was the subject of inherited syphilis. He had suffered from symmetrical interstitial keratitis, and his upper incisor teeth showed broad notches. His forehead was a little suspicious, but otherwise his physiognomy exhibited no peculiarities.

A SYPHILITIC FORM OF GRANULOMA FUNGOIDES.

I NARRATE the following case in detail because it is a most important one. We know that syphilitic affections may simulate almost all known forms of disease, and the question raised by this case is as to whether the infective and incurable malady known under the name of Granuloma Fungoides may not be added to that category. To put the question in another form, we have to ask whether it be not possible that an eruption occurring in a person formerly the subject of syphilis and displaying many suspicious features may prove incurable by specifics and gradually pass into the group of malignant diseases. I have long contended that there are cases which are quite correctly named "Syphilitic Lupus," since their peculiarities depend upon a partnership action of the tubercle bacillus and the syphilitic virus. In like manner there may be a partnership between an inherited tendency to malignant forms of cell growth and that virus, and under such conditions a simulation, or rather a hybrid form of granuloma fungoides, may be one of the results. It is in such a position that I wish to suggest that the following case should be placed. Nor possibly is it one of so small a group as may at first sight be thought. Although I have not seen the consummation of one exactly like it, yet I have seen several which reminded me of it. To take again the comparison with Lupus, it is well known that many forms of syphilitic lupus yield at once to specifics; there are others which do so with difficulty, and

some which resist it altogether. Just so of the cases of syphilitic eruptions which assume peculiar features and threaten granuloma fungoides. Most of them are cured with less or more difficulty by specifics, and only very few pass on to the stages attained in the following instance.

An Eruption symmetrically placed in the limbs resembling a syphilide, but occurring to a healthy man sixteen years after his Syphilis—Steady increase in spite of specifics.

The case of Mr. A. E. H—— was one of the most puzzling which I have seen for long. He was a married man, aged 36, of very fair complexion, and apparently in excellent health. He had two living children, and there was no reason to think that either they or one which he had lost had suffered from syphilis. There was no doubt that he had himself, sixteen years ago, had a chancre, and in all probability constitutional syphilis. Eight or nine years before I saw him he had suffered from diplopia, which was then diagnosed as the consequence of syphilis, and which disappeared under iodides. Since this occurrence he had taken iodides occasionally, but without any very obvious reason. He had, however, for long been the subject of a persisting eruption on his arms and legs and at the anus. This eruption had begun about three years after his syphilis, but it gave him so little trouble that he never sought any treatment for it. The iodide which he took for his diplopia did not cure this eruption.

When Mr. H—— first consulted me on May 2, 1894, he was the subject of an eruption, which he dated back about six months, but which might have been an aggravation of that to which he had been liable so many years. It consisted of dusky red patches like sixpences and shillings on his thighs and legs; but one of the most definite patches was on the left side of his forehead, and was somewhat crescentic, looking like non-ulcerated lupus. He stated that the eruption was rapidly increasing. In colour and general appearance it was exceedingly like a syphilide; but, with

the exception of the patch on the forehead, it was symmetrical, and resembled a secondary rather than a tertiary outbreak. There was not the least reason to think that he had had any second infection of syphilis, and his mucous membranes were quite sound. I wrote in my notes, on the first occasion of seeing him, "I do not think the eruption is syphilitic"; and although I held this opinion with some misgiving, arsenic and chrysophanic acid ointment were the remedies then prescribed.

Three weeks later my notes compared the eruption to a nummular psoriasis, and stated that it was on the increase. At this date (May 21st) a patch had made its appearance on the glans penis, and another on the prepuce. We now administered the thyroid extract in addition to his arsenic. On June 14th my note states that he had three or four patches on the mucous surface of the reflected prepuce, which were covered by thick white pellicle. The eruption had increased, but was still almost wholly confined to his limbs. The thyroid extract had disagreed with his digestion, and a fortnight later we abandoned it.

On June 30th it was noted that the sores on the penis had a very peculiar aspect, being attended by much swelling and covered by thick white pellicle. The eruption was still increasing, many new small spots having appeared on the limbs and lower part of the abdomen; whilst not a single one of the original spots had disappeared. On July 2nd I was able to record that the sores on the penis had all healed soundly under iodides, mercury, and arsenic. The eruption on the skin, however, was in nowise better, and some of the papules were forming crusts and threatening to become rupial. From this date I became more inclined to think that the disease was really syphilitic, and during July, August, and September he took mercury and iodides in increasing doses. In the beginning of August he was slightly salivated, but the eruption was still on the increase. We left off all specifics for a fortnight. Towards the end of August it was noted that there were some papillary growths between the toes. At this date a few of the patches had assumed very peculiar characters. Thus on the lower part

of the abdomen there was a raised patch as large as a half-crown, with evenly rounded edges and an ulcerated granulating surface.

On September 20th my son saw him with me, and, on being informed of the history of the case, felt no doubt whatever that the disease was syphilitic. At this time the patient was in capital health and good spirits; but the eruption had increased fourfold on what it was when he came to me in May, and now covered almost the entire surface, exempting, however, his head with the exception of the single patch on his forehead, and being much less abundant on the trunk than on the limbs. Many of the patches now showed pus crusts, and several were superficially ulcerated. They were not, however, attended by the secretion which characterises rupia, and thus no limpet-shell crusts were formed. The sores on his toes and feet were troublesome, but did not prevent his taking active exercise. At this date I determined to give specifics yet more freely. He had been taking calomel in half-grain doses with iodides three times a day. We now increased the calomel to a grain every four hours, and gave with it fifteen grains of the three iodides in solution. On November 1st I was obliged to suspend this treatment, as it had caused him a very bitter taste in the mouth, and made him feel weak and ill. There was no very definite ptyalism. Not the slightest advantage had accrued to the eruption. It was at this date that Mr. Burgess's portrait was taken, showing the aspect of the eruption on the right thigh, and including the bossy patch which has been described on the lower part of the abdomen. At this time many of the patches on the leg were undoubtedly the seat of thrombosis, for the colour could not be removed by pressure. A remarkable feature in the case had been the persistence of individual papules. I had now watched the case for six months. Many of the papules had remained exactly as they were at the beginning, notably the patch on the forehead, which looked exactly as it did when he first came to me. Others had somewhat increased in size, and it could not be said that a single one had disappeared.

Schedule of Mr. H——'s Case.

YEAR.	AGE.	DETAILS.
1877	19	Had a hard chancre, and took mercury.
1878	20	No secondaries ever occurred.
1879	21	Well.
1880	22	Liable to some eruption. Went abroad.
1881	23	Mr. Morant Baker prescribed arsenic for a patch on thigh.
1882	24	A copaiba eruption, which soon disappeared.
1883	25	Married, being then in excellent health.
1884	26	Good health, but still liable to some eruption.
1885	27	First child born (perfectly healthy).
1886	28	Diplopia and ptosis (cured by iodides).
1887	29	In good health, but liable to a scanty eruption, for which he frequently took specifics without consultation.
1888	30	
1889	31	
1890	32	
1891	33	
1892	34	
1893	35	
1894	36	I first saw him in May. Eruption greatly increased.
1895	37	January 31st: consultation. February 7th: suicide.

The following notes record his progress at the dates given:—

November 14.—An important point in his case is that he has several large coffee-stained patches on different parts. These have been there for years, and are, he thinks, remains of the eruption for which he consulted Mr. Morant Baker. The new eruption avoids these coffee-stained areas. There is a large one on inner side of leg just below the knee; another, yet larger, in left thigh, a little below trochanter; smaller ones on right leg and one on right arm. He has taken arsenic only since November 1st. The patch on abdomen is healing, and I think that all the places are less inflamed. His feet and hands are worse. New patches are forming in the soles of feet and on the hands, on palmar aspects, thumbs, and in clefts of fingers. They have been very irritable, especially at night. His hands had hitherto escaped, and the palms are still quite free, as also the fingers and backs of hands and nails. Some of the patches on the legs are certainly thrombosed; those in other parts, although deeply congested, can be emptied by firm pressure.

November 26.—To-day he feels well. The psoriasis positions are exempt, and so also the flexures. Some of the new papules have little deeply-placed collections of fluid, almost bullæ, in their centres, but there is as yet no true pemphigus. He complains much of irritation, and sleeps badly. From many of the patches dry crusts have fallen, and the sores are healed. He has taken arsenic alone in full doses, m. vij., for nearly a month, and is no better. Some of the crusts have a dirty-looking pus under them.

At this date I advised him to come into a Home in order that mercurial inunction might be used. This was done, and he remained in the lodgings up to the time of his death. Mercurial rubbings and hot baths were freely used. No definite improvement resulted. He lost flesh and strength, and became naturally very despondent.

January 30, 1895.—At this date I requested Mr. H—— to allow me to call in for consultation my friends Dr. L—— and Dr. R—— C——. To this he reluctantly assented, and we accordingly met at his lodgings. The following notes refer to our conference:—

Dr. L—— and Dr. R—— C—— met me in consultation on Mr. H——'s case on Wednesday afternoon, January 30, 1895. At this time the eruption was more abundant than it had ever been before, but in spite of this increase in quantity, it is to be observed that many of the individual patches had diminished in size, and more especially that those which had been inclined to fungate and thicken, were flatter and less prominent. The patient being fully stripped, it was observed that, although the trunk was not exempt, the patches on it were both few in number and small in size as compared with those on the limbs. On the forehead a considerable number of fresh spots had appeared near to the original one, but they were all small, and showed no tendency to thicken. There were no crusts whatever on the forehead. On the limbs a certain number of the larger patches were covered with adherent pus crusts. These crusts could only be taken off bit by bit, as they adhered somewhat, but their detachment did not cause bleeding. The surface left was moist and looked granular, like a condyloma, but did not exhibit any free papillary developments.

The patient at the date of this consultation had been staying for a month in a Home for the special use of mercurial inunction. He had been kept in bed, and inunction had been freely used for three weeks without any effect on the gums. In the hope of procuring ptyalism, hot baths had been used. Finally, during ten days a calomel vapour bath twice a day had been employed, but still without any evidence of action

42. A SYPHILITIC FORM OF GRANULOMA FUNGOIDES.

on the mouth. The patient had become thinner and lost strength, and of late he had not slept well. Excepting on the supposition that the mercury had restrained the tendency to growth, it could not be said that any definite good result had ensued.

In the consultation which followed our inspection of the patient, Dr. L—— expressed a confident opinion that the disease was really syphilis, but suggested that specifics should be now disused and a tonic plan of treatment tried. Dr. C——, however, thought that the disease was “granuloma fungoides.”

The following additional note and comments on the case were written a few days after the consultation:—

On February 1st I again carefully examined one of the largest patches by peeling off the crust. It was a patch on the thigh as large as a half-crown. The crust adhered, but was sufficiently tough to be peeled off with forceps with but little tearing. It was about the thickness of brown paper. Some bleeding was caused by detaching it at the edges. There was no accumulation of pus under it, but the surface was moist. After its removal an elevated flat-topped patch about a quarter of an inch in height was revealed. Its surface was coarsely granular, and very much discoloured, in fact almost purple in parts, by congestion.

At this time there were many patches covered with crusts, similar to the one I had detached, and from some of these a little brown, glairy secretion might be squeezed from under the edge by pressure. The amount of the secretion was, however, very small, and all the crusts were perfectly flat on the top. The patches were not in the least sore, and neither pressure on them nor the peeling of the crust gave any pain.

As regards the essential nature of this case, I do not think there can be much doubt that the patient suffers from a form of dermatitis attended by self-infection. Each patch probably produces infective material, and thus generates others and aggravates the condition. There seems no reason to think that the process involves any material degree of blood infection or deterioration. It is a dermatitis only. The mucous membranes have not suffered, the temperature has not risen, and the patient's appetite and general health have, in spite of the very vigorous treatment, remained good. Whether the disease has any alliance with tuberculosis, or, in other words, whether it is lupoid in its essence, is a very important question. A sister of the patient (whom I have not seen, but concerning whom I have had detailed information from her medical attendant) is the subject of that peculiar form of lupus erythematosus which affects the scalp.

He himself is a fair complexioned, rather delicate-looking man, and in early life suspicions were entertained as to his lungs. Some of his patches, notably those on his forehead, are exceedingly like syphilitic

lupus. The chief difference from lupus has been that the tendency is to continued multiplication of separate patches rather than to the serpiginous spreading of any.

The point for practical consideration seems to be, what is the probable nature of the infective material?—since upon our opinion on this point will much depend the measures to be adopted for diminishing its vitality. Is it probably the tubercle bacillus displaying its activity in tissues modified by bygone syphilis? or, to put it in other words, should we count it as an unusual form of syphilitic lupus? The duplicate antecedents of the patient render such a conception as to the real nature of the malady not at all improbable. To some extent, perhaps, the results of treatment also support it, for on the supposition that tuberculosis takes the principal share, and the long-past syphilis only a minor one, we can understand how specific treatment has proved effectual only in restraining growth whilst it has not prevented increasing multiplicity. I do not know that we should gain much by the use of the term “granuloma fungoides.” We know nothing as to the real nature of the conditions so designated, beyond the fact that they are undoubtedly self-infective, and that it would appear that they can be developed independently of syphilitic taint. It is very possible, however, that in not a few of them the etiology may have been not very dissimilar from that which I have been supposing in the present case. The case does undoubtedly present some features of close similarity to others which have been described as granuloma fungoides, and if we might be permitted to assume that this malady assumes peculiar characters when it occurs in those who have had syphilis, and that our case is an example of such partnership, we shall perhaps have come as near to a nominal diagnosis as is possible.

Soon after these remarks were written the case came to a melancholy termination. The fact that I had wished for a consultation had very much depressed Mr. H——, and he never ceased to tell me that he was sure I had abandoned all hope of cure. I suggested that he should try a change to the seaside, and this still further convinced him that his case was hopeless. On Sunday, February 10, he committed suicide. After his death I obtained some portions of skin. The following report was kindly made for me by the Clinical Research Association:—

“The lesion consists of inflammatory infiltration of the papillary layer of the corium, with subsequent ulceration of the skin. The inflammatory tissue is composed of small round cells not arranged in nodules, and without giant cells or caseation. It does not extend so deeply as the level

of the sweat glands, while superficially it invades the whole length of the papilla, which are distorted in consequence. The skin in the affected area is raised above the general level, the rete mucosum becomes distended by the subjacent growth, and ultimately the surface appears ulcerated, as in specimens C. and D. In these the floor of the ulcer is covered with sloughy material. Neither the sebaceous nor sweat glands take part in these changes. The specimens are numbered A., B., C., D., in order of severity."

It will be seen from this report that the microscope, as I fear is usual in all doubtful cases, gives us no help. We know after its use just what we knew before. I have preserved the sections to which the report refers, and they can be re-examined at any time. I have nothing further to add as regards diagnosis—whether essential or nominal—to what has been said on the preceding page. The case appears to me to be one in which lesions originally in connection with syphilis gradually assumed characters which allied the disease with malignant granulomatous affections.

ON THE RECOGNITION OF STONE IN THE BLADDER.

CASES in which the recognition of a stone in the bladder has been missed, have happened in the practice of all candid surgeons. Sometimes the error has occurred from misapprehension of the symptoms and neglect of the sound; in others the sounding may have been too hasty; and in yet a third class, although by no means a large one, it may have failed on account of pathological difficulties.

Under the first head it may be remarked that the cases divide themselves into two classes. We have first cases in which the symptoms are held to be too slight and vague to suggest stone, and secondly those in which, although the symptoms may be severe, yet they appear to be fully explained by the existence of other disease. That disease is usually the cystitis of enlarged prostate. In many cases of this kind a stone forms insidiously, and is overlooked to the end. These cases may also come into the third category, for the enlargement often makes the use of the sound very difficult.

I will narrate a most instructive case illustrating both these statements.

A case in which the presence of Stones in the Bladder was made difficult of recognition by a very large Prostate—Death—Autopsy.

In the following case the presence of a very large prostate, and the constant use of catheters which it involved, led to the existence of calculi also being undiscovered. The conditions known to be present were supposed to explain the symptoms, and thus the necessary exploration was not

insisted on with sufficient urgency. The patient himself also put special difficulties in the way of a full examination, and never would listen to the suggestion that he might have a stone. He was, however, on a single occasion each sounded by no fewer than three surgeons, myself one of them, and no one detected a stone.

Mr. B—— had been seen by more than one specialist for the bladder before he came under my observation, and had been taught the use of the catheter. He was wholly dependent upon his instrument, and used it very frequently. His prostate was of most unusual size, and bulged like an orange into the rectum. In spite of much suffering from cystitis and the constant use of his catheter, Mr. B——, who was a very temperate man of about sixty, continued to enjoy good general health. He resided in the country, and I saw him but rarely, and never excepting in my own house. He could pass his instrument easily, and was always exceedingly unwilling to allow any one else to use it. His urine habitually contained mucus and pus, but never blood, and he could bear exercise without any increase of discomfort. On several occasions he was laid up in bed for a few weeks at a time, under Dr. H——'s care, by increase in the severity of his habitual cystitis. It is only fair to myself to say that he came to me but seldom, and that I had repeatedly urged as strongly as I could that he ought either to let me visit him at his home and sound him carefully, or that he should come into lodgings near me for that purpose. On one occasion we had taken a room at Fitzroy Square, with the intention of an exploratory supra-pubic operation. He, however, unfortunately made special inquiries as to the probable expense, and eventually declined to come. He was one of those who possibly illustrated the quaint hypothesis that the love of money resides in the prostate gland, being seldom noticed until that gland is large and usually increasing with its overgrowth. Whether that be so or not, Mr. B——, who was very wealthy and in some directions liberal, was saving to an extreme degree in reference to his own health. Not long before his death it was arranged that I was to go to his home and do the long-

talked-of operation, but again he deferred it. A rather sudden failure of strength at length occurred and put an end to all further proposals. About a month before his death he had been up in town to see me, and in the hope of persuading him to submit to an exploration, I had taken him in consultation to another surgeon. On this occasion no sounding was done, and our chief discussion was as to the advisability of an operation. In the course of conversation my friend asked him, "What is your occupation?" To which Mr. B—— promptly replied, "Catheter-passing, and if you had to do it once every hour you would find it quite occupation enough." We debated whether Mr. B—— was in a condition to justify an exploratory cystotomy, and in the end we both of us, as I had before done, strongly urged it on him. After this consultation I never saw him again until the autopsy. His death took place very unexpectedly to his friends. He had been long accustomed to bad nights, but one was worse than usual, and having been much out of bed he became chilly, and collapsed and sank in a few hours.

Through the courtesy of my friend, Dr. H—— of R——, I was enabled to secure a post-mortem examination. Our first procedure was the use of a sound. With the ordinary sound, with a short bulbous foot, I quite failed to strike a stone, although I persevered for some minutes and turned the instrument in all directions. On using a staff with a large curve and turning it so that its point looked backwards, I succeeded in detecting what felt like a large and hard stone. On opening the bladder I found the prostate enlarged in such a manner that a deep pouch was constituted behind it. In this pouch three large stones lay concealed. In using the short-footed staff, after the bladder had been removed, it was easy to show how it might even be directed backwards and yet never strike the stones. I subsequently used the specimen repeatedly at Clinical Lectures at the London to demonstrate the difficulty referred to, and show how it might be surmounted.

ON DERMATITIS OF THE PALMS AND SOLES.

DERMATITIS of the palms and soles may assume various forms. It may be a very chronic or a fairly acute affection. Although in perhaps a large majority of cases connected more or less directly with a syphilitic taint, it is now well recognised that some of its most severe types are in no such association. The cases which I now propose to relate are of interest as exhibiting it as the principal, if not the sole, feature of an obscure constitutional state not inconsistent with a state of apparently good health. Some of these may possibly be related to such affections of the skin in general as are known to us under the names of Psoriasis and Lichen Planus, and a very interesting problem suggests itself as to the degree and kind of relationship which exists between them. Some of the most severe examples of keratosis of the soles which I have ever seen occurred in patients just advancing into senile life, and occasionally I have thought them associated with senile decay of the nervous system. In one of this class a gentleman of more than 60 had his soles covered with thick cracked crusts, as the result, as he believed, of having given way to a most violent fit of passion. He had experienced at the same time some numbness of his soles and liability to incontinence of urine. I had a model made of one of his feet, it being the most severe example of keratosis that I had ever seen. It was for many years in the collection of the London Hospital Museum, but has, I believe, been accidentally destroyed. There was no reason to suspect syphilis. In another parallel case, but not nearly so advanced, the patient was a woman between 60 and 70, who was brought to one of my Demonstrations by Mr. Hichens. There was not the slightest reason to suspect

syphilis, and I diagnosed the case as an example of the senile form. It, however, got quite well under treatment by mercury.

The question of treatment is one of interest not only on account of its importance to the patient, but as assisting in the diagnosis as to cause. Are we to assume that because a disease gets well under the influence of mercury that it was of syphilitic origin? Emphatically I think not. Many chronic inflammatory affections wholly unconnected with specific cause are cured by that important and very efficient drug. The older surgeons were in the habit of salivating the patient for the cure of common psoriasis and many other chronic affections for which we do not now give it. Several of the cases which I have to quote were cured by mercury; but notwithstanding that fact, it is, I think, probable in a high degree that they were not syphilitic.

At page 337, Vol. II., is mentioned the case of a lady of 67, who was probably gouty, whose palms and soles were symmetrically affected by a dry peeling dermatitis. It had been present two years, and was extending towards the wrists. It involved the whole palmar aspects of the hand and digits to the very finger-tips. The nails were only secondarily involved at their free edges, and the backs of the hands were free. There was no other skin disease. I have no note of the progress.*

In Vol. V., at page 76, is the narrative of an example of chronic palmar psoriasis in a girl of 18, who was the subject of inherited syphilis. This is, I believe, a very rare occurrence; at any rate, I have seen very few examples of it. The girl had at the same time bald and sclerosed patches on her tongue, and her mother had also like affections of both her tongue and palms. In the daughter's hands the condition was that of numerous abruptly margined peeling patches. No doubt her occupations had had some influence in aggravating the condition, for she said that she had been

* An important but obvious misprint occurs in the text of this case; the word *arms* in the fourth line should read *palms*.

unable to keep her place as a domestic servant on account of the soreness produced in her palms.

A case in which the condition was undoubtedly syphilitic is given in Vol. VIII., page 220. The patient, a man of 54, in the thirty-sixth year of his syphilis, had for many years had superficial lupoid patches on one fore-arm. On the palm of the same limb he had "abruptly margined mapped-out patches which covered almost the whole palm, and extended on the sides of the fingers to their tips. These patches showed peeling only, but if he desisted from the use of mercury internally they would inflame and crack. He had taken mercury almost continuously for years, but had neglected local treatment.

Here we may note that only the palm was affected, that the patch had spread at its edges, and, making allowance for difference of part, was probably of the same nature as the common syphilitic lupoid affections of other parts.

Severe Keratosis of the Palms or Soles developed symmetrically and rather suddenly—Subsequent development of Lichen Planus (?)—Complete cure.

Mr. F. B——, sent to me by Dr. Robert Fryer. He thinks the first thing he noticed was a slight crack in the right palm in April last. Before that he had never had any sort of trouble with his skin. The left palm soon followed. It was not till June that he observed anything in the soles. He can assign no cause, either local or general. He is thirty-seven years of age, unmarried, has had gonorrhoea, but never syphilis. He believes that his father, who died at sixty, had some chronic irritation on his back. He has had no illness since childhood, when he had three abscesses. He is a pork butcher, rather stout, and in apparently excellent health. In the middle of each palm is a patch, as large as a halfpenny, of much thickened skin. The patch is rough and dry, and is breaking into cracks. There is little or no

congestion at the edges, and no peeling of epidermis. In the right palm roughness is just commencing in front of the ball of the thumb, but this is scarcely perceptible in the left palm. His soles are very severely affected over the heels; the epidermic layer is greatly thickened, and presents a horn-like casing quite hard, smooth, and of a yellow tint. This state in less degree involves the entire sole with the exception of a single band sloping forwards under the middle of instep. This band, which is not more than an inch and a half wide, is quite supple, and in contrast with the rest, which is yellow with a pink margin, it looks conspicuously white. It is, however, simply normal. Under the front part of the foot-tread the skin is thick and yellow, but shows no tendency to break up. Under most of the toes and between some of them there are roughened patches. A deep fissure (quarter of an inch deep) runs forwards near the inner border of the heel patch, into the sole on both sides. This is the only evidence of a tendency to split up which is seen in the soles. The borders of the soles where the keratosis process ceases are slightly congested. The dorsum of the foot is quite healthy. During the last few days an eruption has appeared on the back of the left upper arm.

Oct. 13, 1897.—He has some lichen-eczema on inner sides of both thighs, in cleft of nates just below the groin, and also on the back of right forearm and in bend of left elbow. These were present at last visit.

On September 30th I ordered m. viii. of Liq. Arsenicalis in Tinct. Aurant. It has not disagreed. I think the edges of the patches are more congested. The fissures are very deep. The palms of the hands are somewhat better.

Oct. 23rd.—The group of spots on back of right upper arm has assumed the characters of lichen planus. The spots are smooth and polished and arranged in irregular streaks. There is also a group of similar spots on the front of both wrists. On one leg above the ankle a large group of lichen spots, florid and not polished, has appeared. Some spots are present in front of both elbows. I have pushed the arsenic. It has made him restless at nights. We now give antimony.

The following notes record the changes in treatment and their results :—

February 12, 1898.—For the last month he has taken the antimony in doses of one-fifth of a grain three times a day. It has not in any way disagreed with his health, but no great progress has been made. The patches on the legs, in the crutch and behind the elbows are gone, and have left only deep stains. I now prescribe mercury and iodide.

April 19th.—He went for a fortnight to the South of France. Has been home two weeks. He was better in health, and his palms and soles have steadily improved. No cracks, and the thickening much less. This has been under mercury and iodide.

May 24th.—Three weeks ago his mouth was a little sore, and he left off his pills and mixture. He has been a full fortnight without, and the improvement has been progressive since. His palms and soles are almost well. He has continued the mercurial ointment.

July 18th.—He may be considered quite well. The palms and soles are a little harsh and dry, but that is all. No patches remain nor any material thickening. He is standing and walking all day long.

The cure has been accomplished under the steady use of mercury and iodides. Ung. Hydr. Fort., ʒij.; Adip., ʒij.; Lanoline, ʒij.

I now advise him to continue the pills, but not the mixture.

Above his elbow stains only are left. The patches of "eczema" in crutch and above ankle are well.

On October 13th I was able to record that all remedies had been left off for six weeks, and that the parts affected had remained quite well. The skin of his palms and soles was perfectly sound and soft. On the backs of the upper arms only very slight stains remained. All traces of those on his ankles had disappeared.

It was now exactly a year since I had first seen him. The treatment under which the cure had been completed was the use of mercurial ointment locally, and of mercury and iodides internally. He had taken one grain of Hydrarg. cm. Cret. and four of iodide of potassium four times a day. Latterly the iodide had been left off, and the mercury taken alone. It is to be noted, however, that improvement had begun before mercury was given. I do not think that the apparently good influence of specifics is any proof that the disease was syphilitic. It was not like a syphilitic form; it was attended by eruption on the skin not in the least like syphilis, and the history of primary disease was wholly

wanting. The ointment which had suited best consisted of two drachms of strong mercurial in two ounces of lard, with a little lanoline.

In the case just narrated the patient was an adult man, and as the cure took place under the use of mercury, it may be held to be doubtful whether he told the truth as to the absence of syphilis. For myself I may say that I feel no doubt that he did, but I am glad in substantiation to be able to adduce the following, which is almost exactly parallel and of which the subject was a boy to whom no such suspicion could attach.

Dermatitis of Palms and Soles in a healthy Boy after Chicken-pox—Tendency to Eczema-Psoriasis in other parts.

Master B—— was a healthy-looking boy, aged 12. My first consultation on his case was on April 21, 1898. At that date the whole palmar surface to the tips of his fingers was dry and slightly scaly, but without any circumscribed patches or fissures. The lines of his palms were exaggerated, and showed a white exfoliation.

The condition ceased at the wrist, but its margins were not very abrupt. The backs of the hands and the nails were not in the least affected. Although there were no cracks when I saw him, I was told that there had been very painful ones formerly. The soles of his feet, and especially the heels, were dry, the epidermis much thickened in parts and deeply cracked. Directly under the instep, where exempt from pressure, the skin was sound and soft.

As regards the skin of the body generally, the following conditions were observed. In most parts it was supple and soft, but on the legs, fore-arms, and backs of upper-arms there was some tendency to the nutmeg-grater condition. On the tip of the right elbow there was a small psoriasis patch, and slight traces of a similar one on the left elbow. I was told that he had had patches on both elbows and both knees. The lower parts of his cheeks were dry and slightly

oranny. Behind his knees were some dry patches, slightly scaly.

The history given me was that the boy had never had any disorder of the skin until eighteen months ago, when, after chicken-pox, his palms and soles became rough and dry, and he had patches like psoriasis on his elbows and knees. Ever since that time he had been under medical treatment, and had taken much arsenic. During a long stay at the seaside last summer his skin had much improved, but he was still unable to play cricket or tennis long without irritating his hands. As regards family history, I was told that two of his brothers have rough skins, and that a maternal aunt had recently suffered from eczema of the hands. His father was reported to be gouty.

Comments.—In this case, as in the preceding, we may note that an affection of the palms and soles was attended by slight but quite definite evidences of a tendency to dermatitis on other parts. The character of this varied in different regions, being in some a sort of chronic lichen and in others a dry eczema or psoriasis.

It seems highly probable that the explanation of the severity with which the palms and soles suffered is to be found in the influence of the local irritation to which they are especially exposed. For the parts exempt from pressure and friction were exempt also from eruption. The same explanation may possibly apply to the occurrence of the patches on the elbows and knees. And thus we seem led to the conclusion that the essential cause of the malady was a superinduced susceptibility of the skin which had rendered it unable to bear with impunity those kinds of irritation to which it is naturally exposed. In this feature we trace perhaps a link of natural alliance with psoriasis, lichen planus, and some forms of eczema, in all of which local irritation takes some share in determining the result. In saying this, however, it must be remembered that the differences are also very definite. Nothing is less usual than for the palms and soles to be severely affected in either psoriasis or lichen planus.

My next case is one which yet more definitely connects these affections of the palms and soles with the other forms of dermatitis that have been mentioned.

Very severe Dermatitis—One Palm and the Soles of both Feet affected—Cure under large doses of Arsenic.

Mr. L——, aged 29, in good health, came to me on August 3, 1887. He presented a very severe case of eczema-psoriasis in large cracked patches with thick crusts. They occurred on the legs and backs of the arms, on the genitals, penis, glans and prepuce, on the tips of the elbows, and on the fronts of the knees, in both axillæ. The left palm was affected, not the right. The soles of the feet were almost covered with hard crusts with red borders. It was possible that Mr. L—— had had syphilis six years ago. On September 14th he was better, and the patches were clearing in their centres. The soles of the feet were well, and the palms and backs of the hands were better. He had been staying in Cornwall and taking arsenic.

On October 14th he was very much better, all the scales had fallen, and the patches were fading. He had taken m. xiii. of arsenic three times a day for a month, and the medicine had made him feel nervous and had caused intolerable itching of the skin, so bad as to prevent sleep. The eyes were "a little weak," but he read a good deal. The face was flushed. Good appetite. The soles of the feet were now tender and sore, but the palms of the hands were quite well, and the scalp was almost well.

On February 23rd the skin was quite clear, but stains remained where the patches had been. The medicine had been continued until the feet got so tender as to prevent walking. It had agreed well in all respects.

My next case is of interest chiefly as another example of severe keratosis of the palms in association with an ill-characterised eruption on the skin, and independently of syphilis I am not able to record a completed cure, but under the

liberal use of a mercurial ointment there was improvement which promised cure.

Keratosis of Palms—No Syphilis—Lichenoid Eruption of Limbs.

Mr. Le M——, aged 87, unmarried, consulted me first on February 21, 1898. He was a tall, thin, pale man, bald-headed, and complaining of feeling languid. For two years his palms had been dry with ill-margined horny patches. At one time they had been painful and cracked. There was little or nothing on the soles of the feet. The palmar patches consisted of very dense plates of polished horn divided by cracks. Some papillary patches were also present on the legs. There was no obvious cause; syphilis being denied.

On May 9th no improvement had been effected by my prescription of arsenic and mercury in solution.

On August 10th the palms were much softer, and less cracked under mercurial inunction and antimony internally. There were rough "nutmeg-grater" patches on the backs of the elbows, and some dry, slightly scaly patches on the outer sides of the legs.

FURTHER NOTES ON LEPROSY.

THE tendency of modern investigations to associate tuberculosis with a bacillus received chiefly by food is not without its interest in reference to our speculations as to the cause of the spread of leprosy. The bacillus of leprosy, if not identical with that of tuberculosis, is probably very closely allied to it, and there are some important features in which the two maladies are much alike. When lepers die it is very frequently by tubercular lung disease. Now, those of us who believe that leprosy prevails chiefly through the influence of diet, and very slightly, if at all, by way of direct contagion, find in what has recently been proved as regards tuberculosis important collateral confirmation of our creed. Leprosy has disappeared from very many regions, more especially inland ones, simultaneously with the advance of civilisation, an improved dietary, and the disuse of salted fish. It still lingers, or even thrives, in many places, and chiefly amongst communities which in respect to one or other of these matters have not shared in the general advancement of the world. It may be that the motto of the anti-tuberculosis army will be, "No uncooked milk, no underdone meat." I feel very confident that that of those of the friends of the leper ought long ago to have been, "No uncooked fish."

In connection with the disappearance of leprosy, it is very important to remark that so far as our knowledge at present goes it has left nothing behind it. We have no half cases, or slight forms, or modified maladies. Its manifestations seem to be somewhat more definite and

positive than those of tuberculosis. It is either leprosy or nothing. Nor are there any sporadic cases springing up here and there in communities which have long been free. These facts may at first sight seem in favour rather of spread by contagion than of production by an article of food. One might have imagined, on the latter hypothesis, that there would have been here and there a devout fast-observing Catholic or a lover of salted fish who would have eaten himself into leprosy on his own account. In reply it may, however, be said that in the main the facts are in accordance with what I have suggested as probable on the food-hypothesis. When leprosy is dying out of a community it does die out very gradually, occurring only in isolated cases and in single individuals living at considerable distances from each other. We have no sudden outbreaks or recrudescences such as are observed in all truly contagious maladies. The results of the recent Congress at Berlin have strongly confirmed these statements. No examples were produced showing that the disease had occurred sporadically in inland communities otherwise free. But many examples showing that the disease is, and has been for long, prevalent to a slight extent in localities not previously recognised as its haunts, were adduced. This sort of prevalence had long been suspected by those conversant with the malady, and the Berlin revelations were simply additions in detail to our knowledge of medical geography. All the newly recognised centres are, I believe, if not on the seaboard, well within the reach of salt-fish. Meanwhile a single sporadic case has also been recently placed on record, a patient from a town in Brittany having been admitted into the Paris hospitals with leprosy, the diagnosis of which was confirmed by the microscope. Such a case coming from a district in which leprosy had not been known for centuries, presents a very difficult problem for the contagionists, whereas it is very acceptable to those who think that the disease originates from food, and may therefore be developed in connection with personal proclivities as to diet.

Mosquitoes in relation to Leprosy.

The hypothesis that the bacillus of leprosy is conveyed by the agency of mosquitoes has, at first sight, much plausibility. The credit of its suggestion has already two claimants. Dr. Sommer, of Buenos Ayres, in the *Semana Medica* notes that in hot countries leprosy prevails where there is much water and consequently many mosquitoes. He thinks that this explains the acknowledged prevalence of the disease in fish-eating populations, since fish and mosquitoes both occur in association with water. To him Dr. Ashmead rejoins by reprinting an article of his own, dated Jan., 1896, which contained the same suggestion. Dr. Ashmead does not, however, limit his theory to the idea that the virus is conveyed by the insect's haustellum. He thinks that eating fish such as carp, which have fed on the eggs of mosquito, may be a cause. He adds, in words the equivalent of which I have myself many times used during the last forty years, and which again I most fully endorse : " In leper countries, all intelligent persons should unite to prevent by persuasion, and all legal means, the consumption of raw fish."

The part taken by mosquitoes in the conveyance of the malarial parasite is now fully acknowledged, and there are many facts as regards leprosy, its prevalence, and its decline, which are fairly parallel with those as to intermittents. Both recede and disappear in temperate countries before the progress of improved agriculture and the drainage of swamps, and both are prone to attack those who go to reside in districts where the malady is endemic. There are, however, certain facts which make me feel incredulous as to the mosquito-theory, and incline me to still hold that uncooked or badly cooked fish is the real cause, quite independently of that insect.

1. Leprosy prevails on the seaboard, where neither mosquitoes nor mosquito-eating fish are found. In Norway these insects are chiefly troublesome at certain inland spots where there is pond water, but these are not the haunts of leprosy.

2. Travellers visiting districts where leprosy is endemic, seldom or never take the disease unless they adopt the habits of natives as regards food. No one dreams of danger from visiting Norway, and the infection of Europeans even in India is very rare. The reverse is the fact as to intermittents, which casual visitors to the district often catch.

3. We have no reason to believe that mosquitoes were ever common in England, yet during the Catholic fish-eating days leprosy was abundant. It disappeared from England long before the drainage of the gnat-breeding swamps was accomplished.

4. The bacillus of *Lepra* much resembles that of tuberculosis, if it be not identical with it, but we have no reason to believe that tuberculosis is spread by insects. On the other hand, the evidence as to the importance of food as a vehicle of the bacillus has increased much of late.

5. Probably there are many places where leprosy prevails, and where mosquitoes are unknown. Defective knowledge of topographical detail prevents my naming any special places.

6. If the poison were conveyed by insects we should probably have some localities where every person, residents and visitors all alike, would suffer, just as there are places where no one escapes malaria. This, however, is not the fact with leprosy, the prevalence of which much more nearly resembles that of tuberculosis.

CASES IN ILLUSTRATION OF SCROFULA.

THE degree and kind of relationship which obtains between bacillary tuberculosis and the various forms of disease known under the name of scrofula is a topic of the deepest interest. If we got rid of the specific poison of Rabies we should hear nothing more of anything related to Hydrophobia, and the same assertion is true as regards the virus of smallpox and that of syphilis. If, however, we could get rid of the tubercle bacillus, should we be free from scrofula? It may perhaps be replied that many things pass under the name of scrofula concerning which it is by no means proved that they have anything to do with tuberculosis. It will, however, if I mistake not, be found very difficult to draw any definite lines, or even to make it reasonably probable that any one of the scrofulous family ought to be expelled as being no real relation. Lupus vulgaris stands, perhaps, as our best representative malady in this respect. There is perhaps no single scrofulous malady concerning which the collateral evidence of relationship with tubercular maladies is weaker. Lupus patients rarely become phthisical; they are often in robust health, and in probably a majority of cases the family history is negative. Yet respecting lupus vulgaris it has been demonstrated by innumerable observations that the tubercle bacillus may be detected in the apple-jelly growth which characterises it. It is certainly, despite the negative facts, a tubercular affection. The insignificant eruption now known as Lichen Scrofulosorum stands in the same position. It is acknowledged to be tubercular on histological evidence, although it bears no outward resemblance to other affections of that class. We are thus driven to the conclusion that the local manifestations due to the presence of the tubercle bacillus may be most diverse.

It becomes, then, exceedingly difficult, if not impossible, to make it probable concerning any other given affection of the joints, bones, glands, skin, or mucous membranes, that they are not due to that cause.

One may in times past have felt inclined to suggest that the term tuberculosis should be given to processes in which the bacillus can be proved to take a part, and that inasmuch as it is admitted that some peculiarity in tissue-organisation is necessary in order that the bacillus may be allowed to flourish, we might give the name "Scrofula" to inflammations resulting directly from such enfeebled tissue organisation without the actual presence of the bacillus. The tendency of advancing knowledge has, however, been to supply each year more and more evidence of the actual presence of the parasite in the affections referred to, and thus to suggest the conclusion that all "Scrofula" is tuberculous.

A very important part of the problem before us is to determine the relationship of the bacillus to the very various forms of inflammation which may denote its presence. Are these varieties wholly determined by reference to the precise tissue attacked, or do the idiosyncrasy and existing proclivities of the individual exercise an important influence? Opinions have been recently expressed by eminent authorities which tend to discredit the long-cherished view that tubercular affections are hereditary. The now popular theory is that they are communicated either by food or by direct contagion, and that in all cases their manifestations are a matter of *de novo* development in the individual. I may acknowledge at once that such is not my own opinion. One of the strongest arguments in favour of the tubercular nature of scrofula is, I think, to be derived from the fact that these diseases are interchangeable in transmission. Many fallacies, I know, attend the attempt to collect family histories, but in spite of such it is, I hold, established beyond doubt that amongst the relatives of those who have suffered from unequivocal tuberculosis we find most of our cases of chronic gland disease, bone disease, ulcerations of the cornea, and the like.



In the series of illustrative cases which I shall now adduce especial attention will be given to family history and to the relationship which different manifestations of scrofula appeared to bear to each other.

Multiple Strumous Disease of Bones and Joints.

The lithograph with which my series commences is from a photograph taken of a poor boy who was brought to one of my Clinical Demonstrations some years ago. He was the subject of almost innumerable strumous abscesses, from which he had suffered for more than a year. In most places the suppuration appeared to have commenced with the periosteum, but the cellular tissue had been also severely implicated. In the digits many joints had suffered. His lower extremities were affected as well as his hands and arms, but he had no gland disease. There was no reason to suspect inherited syphilis.

I regard this case as one of an important group of periosteal struma, and as illustrating the general law of PREFERENTIAL INFECTION. Under this law an inflammatory strumous process originating in any given tissue tends for a time to infect structures of the same kind throughout the body. Thus a multiple periostitis, a multiple lupus, a lichen scrofulosorum with many patches, or a multiple gland affection may be produced. As I have often taken occasion to demonstrate in the case of lupus, the period of infective virulence is limited, and after a certain time no further lesions are evolved, and the patient recovers so far as is possible. Sometimes single lesions persist.

I have seen many examples of this multiple periosteal struma, some of them even more severe than the one here depicted. Some of them have exhibited in a very remarkable manner the subsidence of all active processes and the repair of parts. Their subjects are almost always young, but now and then senile examples of it may be seen.

Not unfrequently it is difficult to establish the negative as

regards the inheritance of syphilis, and of this my next case affords an instructive illustration.

*A case of Multiple Abscesses in connection with Bones
in a young child.*

A case involving much difficulty in diagnosis came under my notice on June 7, 1898. The question was as to whether certain swellings which had formed in a young child in connection with various bones were indications of inherited syphilis or not. The patient was two years and a half old. Her parents were separated, and it was thought not improbable that the father had had syphilis, although this was denied by him. The child's mother came with her, and she appeared to be in excellent health, and had never had any reason to suspect that she had acquired any taint.

The condition of the patient was as follows: She was well grown, but thin, very pale, and of flabby tissues. The bridge of her nose was somewhat sunken, and her features much deformed by swellings in connection with both sides of the lower jaw and with the frontal bone. On the latter, under the eyebrows and at its sides were large nodes which fluctuated freely. The skin over them was not in the least reddened, nor did they appear to be painful. Other similar swellings were present over the parietals, just below the left elbow, and in both feet. The thumb of the left hand was greatly swollen, and presented two large ulcerated surfaces which had followed the giving way of a periosteal abscess. On the back of the right hand was a large swelling which fluctuated very freely. Thus the child had at least a dozen different abscesses, all of them "cold," and all commencing in all probability from bone. None of them were inflamed, and she allowed us to examine them without wincing. In addition, there was said to be a discharge from the nose and throat which smelt badly. This odour I could not detect. Her teeth were in good condition, and she had no skin disease.

The history given was that during the first two years of

life the child had appeared to be in excellent health, and had needed no treatment. The first thing noticed was swelling of one thumb, and this had preceded any other swelling by a month or six weeks. Then the other abscesses had successively developed, and the child's health had failed. At first the diagnosis of infantile scurvy had been given, then that of tuberculosis, and lastly that of inherited syphilis. Mercury and iodide of potassium had been prescribed. Under the former it was thought that the abscesses had shown tendency to diminish, but under the latter they had increased.

I ventured to give a confident opinion that the case was not one of hereditary syphilis, and for the following reasons : (1) All the abscesses had supplicated rapidly and without any obvious tendency to periosteal deposition of new bone. (2) They had been painless. (3) They had not improved under iodides. (4) All history of infantile symptoms was absent.

My diagnosis was that they were the result of an infective periostitis, and that the inflamed thumb was the primary source of the trouble. From it, in all probability, had been shed the germs which had infected the other bones.

Whether the process was in any definite manner associated with tuberculosis might seem to be open to some doubt. The child was in excellent health up to the date of the swelling of the phalanx of the thumb, and from that time the tendency had been to rapid suppuration resembling rather that which we meet with in the multiple abscesses of pyæmia than those due to tubercle. The restriction of the disease to one and the same tissue, the periosteum, had been remarkable. Nowhere was there any reason to suspect that an abscess had commenced by induration of the cellular tissue.

My own view is, however, that in all probability the tubercle bacillus does take a share in determining the infective nature of the inflammatory products. *Mutatis mutandis*, the case is in all respects very parallel to some of the more severe examples of multiple lupus, such, for instance, as that of the boy L—— recorded in Vol. IX., p. 77.

In his case the first eruption was severe and almost rupial in appearance, and not in the least like lupus.

In the subsequent treatment of this case I removed from many of the abscesses fragments of necrosed or softened bone. Some of the phalanges came away almost entire. Large quantities of semi-solid curd-like lymph were also scraped out from several of the abscesses. This lymph would have been regarded by our forefathers as characteristically strumous, and as such I am inclined to accept it, although examination failed to detect the presence of bacilli.

The suppuration from these numerous abscesses was at one time profuse, and the temperatures were for weeks above normal, sometimes as much as two degrees. As a rule the child maintained an excellent appetite, but at one time the general strength threatened to fail. Under my advice the child was taken to reside at the seaside, and is, I believe, now in a fair way to recovery. Having witnessed the remarkable recoveries of similar cases, I have strongly urged that under no circumstances amputation of any part should be done, however unhopeful the conditions may for the time appear.

Cases of Tuberculous disease of the Axillary Lymphatics without obvious exciting cause.

Many years ago, at the Metropolitan Free Hospital, I excised from the armpit of a woman who was past middle age a large mass of indurated glands. The lump was as big as a small fist, but somewhat flattened and cakelike. It was very firm, and I may confess that the operation was done under a mistaken suspicion that it was malignant. No source of primary infection could be found either on the hand or elsewhere. In those days operations were far less frequently resorted to, and the excision of scrofulous glands was regarded as not necessary, and in some sense a bad practice. It was therefore with feelings allied to chagrin that I found, on examination of the mass removed, that it consisted of glands crammed with

crude tubercule, and which were firmly matted together by dense fibrous tissue. I am not able to give any facts as to the patient's family history, but I have preserved a good portrait showing a section of the glands.

Since the case above referred to I have seen a certain number which resembled it in being examples of what may be called primary tuberculosis of the axillary glands, and several of the patients have been past middle life. Some years ago I had to visit, in a provincial town, a lady, aged 71, from whose armpit a mass of this kind had been excised, and in whom the operation wound had not done well. Other cases have occurred in younger patients, of which the two following are examples.

A boy of 14, who was brought to me by Mr. Gilford, of Reading, afforded an example of what was apparently primary disease of the axillary lymphatics. His right armpit was filled by a mass of glands, which adhered together, but not to the surrounding parts. There was no evident tendency to suppuration, but some slight tenderness, and during the last week or two there had been evening increase of temperature. Not the slightest trace of a sore could be discovered on any part of the hand or forearm. There was a strong history of tubercular affections in the lad's family, and he himself looked delicate, although not definitely out of health. He was much freckled, a condition which may, I believe, be taken as, to some extent, implying delicacy.

I advised that the armpit should be cleared of all glands at once. Although as yet the cervical glands had escaped, there could be little doubt that the process was an infective one, and that there was every probability that they would become implicated in the future. The case seemed to stand between tuberculosis and lymph-adenoma.

Tuberculous Axillary Glands, with history of Pulmonary Tuberculosis in family.

On January 25 I showed at one of my Demonstrations a number of glands which had been excised from the arm-

pit of a young lady. Some of them showed only enlargement, but the larger ones consisted chiefly of crude tubercle. Some were as large as small walnuts. No peripheral lesion had ever been observed. The patient was aged about twenty-six, and she had discovered the enlargement by accident about six months ago. She was in delicate health, but had no obvious lung symptoms. A most important point in her family history was that no fewer than four of her maternal aunts had died of pulmonary phthisis.

In speaking of these cases as primary tuberculosis, it must be said that they are probably only such in appearance. In all probability the real infection comes from the hand. Very possibly inflamed chilblains may supply it. The gland mass, in my experience, is almost always below rather than in the axillæ, a fact which strongly favours the suggestion that the source of infection is from the hand rather than from the chest or neck. It is perhaps not improbable that the original infection or irritation precedes by a long interval the obvious development. Inflamed lymphatic glands may, it is to be suspected, remain through long periods in a quiet state, and then finally, in connection perhaps with some failure in general health, take on disease—that disease may be either definite tuberculosis or the inflammatory hypertrophy known as lymphadenoma, or Hodgkin's disease.

Cases in Middle and Senile periods of life.

Without doubt age exercises a large influence in determining the course of inflammatory irritation or infection of lymphatic glands. The younger the patient's tissues, the more likely it is that suppurative inflammation will complicate the infective process and perhaps arrest it. The older the patient, the more likely within limits that the disease will run a malignant course. There are, however, certain rather rare examples which Paget has well named senile scrofula, in which patients above middle age, or even distinctly senile, become the subjects of tuberculous affections of the cervical or axillary glands. Of such cases I

have the notes of three or four before me. I cannot, however, assert respecting any of them that they ran exactly the course of scrofula in youth.

In one of these, a woman of fifty-six has been the subject for ten years of enlarged cervical glands. They almost disappeared six years ago under the sulphide of calcium and arsenic, but recently have again increased. There is a strong history of tuberculosis in her family.

In another, a man of near sixty, whom I had sent abroad, with some benefit to his cervical glands, two years before, died from an obscure illness, which was possibly the end of lymph-adenoma.

An important case, which I believe I have already mentioned in print, is that of a gentleman aged 49, from Devonshire. He was sent to me in November of 1895 with a large mass of glands in his neck and armpit. Those in his neck had suppurated, but a large mass in the armpit consisted of hard glands, which were still movable. At the age of 19 tubercular disease of his right apex had been diagnosed, and he had been sent to Madeira. He had lost a son from tubercular meningitis and an uncle from phthisis, and he was himself the subject of an old-standing perforation of the septum nasi. Both he and his son had suffered much from pustular chilblains on the ears and fingers. In spite of these ailments he was a florid, healthy and vigorous-looking man. He derived much benefit from the sulphide of calcium and a sea voyage. Under these measures the abscesses in the neck healed. I strongly advised him to have the gland mass in the armpit excised, but I believe he shirked the operation.

A lady, aged 56, whom I had seen on account of enlarged glands in October, 1884, came under my care again in July of 1896, and her case well illustrates the very slow course which gland disease may sometimes take in middle periods of life. The gland first affected was behind the sterno-cleido mastoid. As she was much out of health I advised her to take tonics and try change of air. Under these measures the gland first affected shrivelled, but when she came to me thirteen years later there were many enlarged glands

on both sides of the neck. All of them were movable and free from inflammation, and I much feared that she would become the subject of lymph-adenoma. She was delicate looking, but emphatically denied that she had ever been suspected of phthisis or that any form of tubercular disease had been recognised in her family. As a child she had had very bad sore throats after an attack of scarlet fever, and quite recently had thrice suffered from catarrhal laryngitis.

A singular case of what was perhaps senile struma came under my observation in the person of an old lady aged 66. She was very thin and pale, but of active habits, and had been accustomed to manage her own farm. Both her parents had died comparatively young, and all her brothers and sisters were dead. She knew of neither gout nor rheumatism in her family. It was for a large chronic abscess about the knuckles of her right hand that she came to me. The hand had first begun to swell in October of 1897, and, as she believed, in consequence of her having held the reins in that hand during a long drive in the rain. The swelling was very considerable, but was absolutely without pain. Poultices were used, and within about two months several ulcers had formed. When she came to me in June of 1898 there was still great swelling, involving the knuckles and adjacent parts of three fingers, and there were two or three ulcers with undermined edges. The swelling appeared to be caused by soft granulation tissue, with much white curdy material. I removed much with a scoop, but did not touch diseased bone.

This patient's case reminded me of one which I saw many years ago, and of which the patient was again a woman in somewhat feeble health, and near sixty years of age. There was great swelling of the parts between the thumb and forefinger, and one or two sinuses led into a soft mass, which easily bled. The microscope having declared that the structure was sarcomatous, I amputated the thumb and forefingers. Subsequent examination led me to believe that the conditions were those of struma rather than sarcoma. There was much curdy material mixed with the granulation tissue, and the latter was quite ill defined. The patient

remained well as regards any local recurrence, but had subsequently other symptoms of struma.

Severe Multiform Scrofula with feeble circulation—A peculiar form of Bazin's Malady in adult life.

Miss P——, a lady of 35, was sent to me on June 3, 1897, by Dr. Hearnden, of Sutton. She had in early life suffered most severely from scrofula in various forms, and she was now the subject of a very peculiar condition of the legs.

In the first place the legs were mottled all over with dark-brown fire-stains, but in addition to these there were numerous patches of induration involving both skin and cellular tissue, some of which appeared to be on the point of ulcerating. The nominal diagnosis was obviously a form of Bazin's malady, and as regards essential causes it appeared clearly to be in association with a tubercular diathesis and recently great subjected chilliness and consequent exposure to fire heat.

It may be well to briefly enumerate the strumous conditions which were present in this case.

The neck on both sides was seamed with the scars of glandular abscesses. There was a scar on one cheek, and another on the chest. All these had for long been perfectly sound. One forefinger had been amputated at the age of 15 for disease of the bone. On both arms were numerous scars, quite sound, left by a sort of strumous lupus. There had been large ulcers on the corneæ at the age of 12, which had left opacities; that on the left being especially conspicuous. Formerly she had had lung trouble, and had spat blood; and tubercle in both apices had been diagnosed.

Her family history was that a maternal uncle had died of consumption, two paternal cousins of gland disease, and one of phthisis. She was herself the eldest in her family; two younger brothers and one sister were living and in good health; her mother had died of bronchitis, and her father of tumour of the liver.

As regards peculiarities of circulation the facts were as

follows. As a girl she had never been liable to chilblains, but her hands and feet would often become cold and dusky. This tendency to lividity ceased in adult life, and during the last two years she had suffered from chilblains. In childhood she suffered much from aching pains in her legs. From the age of 8 onwards she had been liable during winter to attacks of what had been called erythema of the legs, which prevented her from walking.

The measures of treatment on which I insisted in this case were chiefly directed to favouring the circulation by means of clothing, change of climate, and a very liberal diet. Miss P——, at my suggestion, spent the whole of the following autumn and winter in Corsica, at Ajaccio. She returned to me in August of 1898, fourteen months after her last visit, a quite changed being. All traces of the indurations on her legs had disappeared, and she had gained in flesh and colour. She told me that her legs had been gradually getting well during the whole of the winter, and that she had been able, in the Corsican climate, to take exercise freely. She considered that they had been quite well since April. I strongly advised her to return to Corsica for the next winter.

This case instructively illustrates several very important points in reference to the group of maladies which are known as scrofulous. In the first place it shows, what is not very common, that the different forms may be associated in the same person. Next it affords important evidence as to the possibilities of local recovery and repair. Thirdly, we have to note the influence of feeble circulation as a partner in causation, and, finally, the good results of climatic treatment.

Pulpy degeneration of the Synovial Membrane of the Knee-joints—Tuberculosis in family.

Mr. La C——, ætat. 32 (April 13, 1894). He had syphilis eight years ago. His mother is crippled with rheumatism, and several of her relatives also. A sister died of phthisis. He is a tall, pale-complexioned man. After his secondary

syphilis he had ulcers on his legs like those of Bazin's malady.

March 15, 1898. Nine months ago he struck his knee against a table and caused himself considerable pain. His knee swelled and was blistered. Subsequently he had Scott's dressing. The knee has continued swollen. It is now much enlarged, with pseudo-fluctuation at several points not very definite. The pouch of synovial membrane under the quadriceps can be easily felt as a round thick mass ending above by a very definite border. The skin is not reddened. There is no free fluid in the joint. It is clearly a condition of pulpy degeneration of synovial membrane, and probably tubercular. He can still stand and walk upon the limb, but he is liable, when the limb is at rest in his chair or in bed, to have it give starts which are attended by exquisite pain. These are clearly the starting pains which used to be supposed to indicate ulceration of cartilage.

On the association of Lupus with Scrofula and Phthisis.

A very definite example of the association of various forms of scrofula with lupus, and of the whole with hereditary tuberculosis, has been recently under my observation. Its subject is a girl of fifteen, tall, and of fair complexion. Her ailments began at the age of five with "strumous ophthalmia," and she suffered severely from ulcers on her corneæ for several years. Not long after this began she became the subject of lupus vulgaris in its multiple form, and had patches of it on her right elbow, on her neck, and on both thighs. For these she has been under treatment ever since, and under very efficient measures carried out by a surgeon at the seaside all the patches excepting two have been cured, leaving very large but pale and sound scars. She had also a gland excised from her neck, and had several glandular abscesses. Since the age of seven she has regularly spent half her year at the seaside, and has had every advantage as regards food. At the present time her eyes are free from irritation, but show

filmy traces of the former ulcers in addition to the large scars already mentioned. She has a small patch of lupus under her chin, and a very large one surrounding her right elbow, which extends upwards and downwards, and has quite crippled the movements of the joint. This patch has still an ulcerated and crust-covered border, and is still aggressive. Quite recently there has been developed on the labia and adjacent parts of thighs and pubes an acute pustular eczema of scrofulous type, and around it many discrete pustules. These I should suspect to be due to contagion from discharge from the lupus patch on the elbow. The condition is not lupus, and has been present only two months.

Now the all-important facts in the family history are as follows: Her mother is of dark complexion and strong constitution. Her father, on the contrary, was delicate about the time of his marriage, and had a suspicious cough. A year after his marriage he lost one of his brothers in phthisis, and since that five others of his brothers and sisters have succumbed to the same malady. Our patient takes after her father, and is, like him, of fair complexion.

(To be continued.)

FRAMBOESIAL SYPHILIS.

A CASE of some interest as illustrating the occurrence of a framboesial eruption during the course of English syphilis, came before us on Nov. 9th. The patient was a stout, gross man of more than middle age. It appeared that he had contracted chancres on his penis and on his upper lip at the same time. The date of infection was probably four or five months ago, and the primary sores were still present in both situations, with also enlarged glands under the jaw. His skin generally showed in a very faintly marked form the remains of an erythematous eruption. In addition to this, and probably subsequent to it, there had been developed on the upper part of his chest and neck large papules, which had become abraded and were threatening to fungate. The most characteristic framboesial growths, however, occurred in the folds of the groins and between the nates. In these situations there were seen numerous round "granulation-papillomata" as large as sixpences or shillings, a quarter of an inch or more in elevation. Many of them had coalesced into irregular masses, but some remained discrete. These latter were in all respects similar to the growths which occur in yaws. It will be obvious that there is no real distinction between growths such as are here described and condylomata. Where several framboesial growths have coalesced, and a flat-topped area of elevation results, the condition changes its name and "condyloma" becomes applicable. The yaws eruption is, in fact, a sort of generalised condylomatous outbreak on the surface.

In attempting to explain the differences presented by

the eruptions due to syphilis in different persons we must take account of various factors.

1. The anatomical conditions of the part. Thus condylomatous (granulation-papilloma) growths occur to parts in which moisture and warmth are favoured by the mutual apposition of opposed surfaces;—at the anus, between the buttocks, in the folds of the female genitals, in the groins and axillæ, or on the mucous surfaces,—tongue, tonsils, cheeks, oral commissures, &c.

2. The age of the patient. They are more prone to occur in the young, in whom growth-processes are more active than in older persons.

3. Personal peculiarities as regards the skin and subcutaneous tissue. Thus fat persons are more prone to condylomata in the flexures than thin ones.

4. The race. It is quite possible that the Celtic race is more prone than the Teutonic to this form of papillomatosis. This may perhaps explain the occurrence of Button Scurvy and Morula, in Ireland; of Sibbens in Scotland, and may also be associated with the liability to granular lids.* As regards the dark races, there can be little doubt that they are all prone in a remarkable degree.

5. The climate, season, and temperature. Just as local heat and moisture on the skin of the patient favours these growths, so probably does a moist and hot climate.

6. Lastly, something, perhaps much, must be credited to idiosyncrasy, meaning by that term individual peculiarities of which no explanation can be given.

* So definite is the superior proclivity of the Celtic race to granular conjunctiva, that Sir William Bowman gave that condition the name of *Oculus Hybernicus*.

ON YAWS.

A CONVERSATION.

AFTER one of my Demonstrations, in which I had roundly asserted my opinion that what is called Yaws is the same disease as Syphilis, a conversational discussion occurred, which it may be of interest to record. The chief interlocutors were a very distinguished colonial surgeon and myself.

C.S. I cannot accept your proposition as to the identity of syphilis with Yaws. I have practised for a quarter of a century in countries where both occur, and I declare that they are easily distinguished.

EGO. I admit that it may not be difficult to distinguish a well-characterised example of framboesial syphilis from one which is not framboesial, and I admit, also, that framboesial eruptions are much more frequent in tropical syphilis than in European. I suggest, however, that the diagnosis which you say is easy, rests only on external appearances, and that your classification of cases is, to a large extent, arbitrary.

C. S. You will find that all those who have had experience and seen Yaws where it is endemic will agree with me and tell you that is certainly distinct from syphilis.

EGO. Not quite all. I must remind you also that we have recently had two cases of African Yaws brought to England, and that in neither could we distinguish the disease from syphilis. One of the patients I produced in this room.

C. S. I should much have liked to have seen your patients. You are sure that they were Yaws?

EGO. Both had been so diagnosed by well experienced surgeons abroad ; in both contagion from Yaws had occurred,

and in both the primary sore was on the upper extremity. In both I may add the eruption was framboesial, that is attended by fungating growths.

C. S. Then why do you call them syphilitic?

EGO. In each case the eruption was polymorphous, consisting mainly of dusky papules, and in each there was palmar psoriasis. When I brought one of the men here, and we had him stripped before us, no one doubted that his condition was exactly like that of severe secondary syphilis. He was covered with superficial sores and papules, and had at that time no framboesial growths. Both patients have promptly got rid of almost all symptoms under treatment appropriate for syphilis. In one of them the patient, a surgeon, had accidentally inoculated his finger from a Yaws sore.

C. S. Did they have characteristic throats?

EGO. No, I must admit that neither of them had anything in the least characteristic on the tonsils. It is, however, very common in European syphilis to see the throat symptoms omitted, and with all deference to your experience, I submit that sore throats from any cause are not common in hot climates.

C. S. Oh, I beg your pardon, we see plenty of sore throats in India.

EGO. That may be; still, from what I have been told by many, I believe that they are much less common than in England, and that we fairly so explain the asserted fact that in Yaws there is a skin eruption only and no affection of the throat. Besides, let me suggest that if a Yaws patient had a sore throat you would at once diagnose the case as syphilis and not Yaws.

C. S. If you had seen as much as I have of the Yaws eruption, I am sure you would admit that it is very different from that of syphilis.

EGO. But let me submit that it is proved by the production of cases, that in European syphilis the eruption may be characteristically framboesial. I admit that the cases are not common, but they are enough for my purposes. My proposition is that syphilis may produce framboesial erup-

tions in any race and in any country, but that such are more common in hot climates and on pigmented skins than in Europe and in white races. Have you, may I ask, ever seen Yaws in a European?

C. S. Never.

Ego. How do you explain that fact?

C. S. I think that they do not expose themselves to the risk of contagion.

Ego. But Yaws is virulently contagious?

C. S. Oh, yes. I have seen it affecting a whole household, father, mother and children and perhaps grandfather, and all together, and all exactly alike. Mind, that is in the country, not in the towns.

Ego. Is, then, Yaws more common in rural districts?

C. S. Yes, in the places where I have practised (Ceylon and India), in towns you rarely see Yaws, but plenty of syphilis; but in the country districts plenty of Yaws and no syphilis.

Ego. Exactly similar statements have been made to me by other observers. I have even been assured that in some islands in the South Pacific Yaws is prevalent, and has been so from time immemorial, whilst syphilis is unknown. What is your inference from such facts?

C. S. If you have one malady in one place and the other in another, and both keep to their type, I hold that they must be distinct diseases.

Ego. How very differently the same facts strike different minds. To me this local substitution of the one for the other affords the strongest reason for thinking that they must be the same malady modified by difference in surroundings. Why should Syphilis be absent in the country districts and Yaws absent in the towns? Both are very contagious, and to both it is likely that the risks of contagion would be as great in town as in country.

C. S. But how, on your hypothesis, can you explain the difference presented?

Ego. In the first place, will you allow me to hint that the facts may perhaps be stated a little too sharply. It may be that some of the cases diagnosed as syphilis in towns do

show some framboesial manifestations, and it may be that some of the cases called Yaws in the country are not very well marked. What you have told me as to Yaws running through families, reminds me that when I was in Norway, thirty years ago, Professors Boock and Bidentkap and others told me exactly the same as to syphilis. They said that in out-of-the-way peasants' homes, where three generations often lived under one roof, it was not uncommon for all to become simultaneously affected with syphilis, and for the disease to be very severe. In such cases the primary focus was usually supplied by a young man who had visited a town and obtained the disease in the usual way. In all the others the contagion was non-venereal (by drinking vessels, towels, kissing, and the like), no precautions having been observed. I suggest that it is the same with your family groups of Yaw cases.

C. S. But still, why, in the case of a family group, should all the patients have the same kind of eruption?

Ego. You must please observe that part of my contention is that peculiarities in the individual determine the peculiarities of the syphilitic eruption, in one man framboesial, in another papular or scaly. This being admitted, we can see that all the members of a family may display the results of peculiarities which they possess in common. The same explanation may apply to local outbreaks of so-called framboesia. It may have been the fact that most of the individuals in the village were related, and of similar tendencies.

C. S. I see you are aiming at the outbreaks of sibbens in Scotland and of button-scurvy in Ireland. To my mind, the disease so well described by Sir Dominic Corrigan was undoubtedly Yaws. If sibbens and button-scurvy were nothing but syphilis, why should we not have them now? we have plenty of syphilis extant still, but they are gone.

Ego. If they were Yaws, why should we not have Yaws still? The two maladies, if they be two, are equally contagious, and it is as difficult to account for cessation under the one name as the other. In avowing your belief that these maladies were identical with the tropical Yaws of to-day, I think that you give me a very strong argument,

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for I believe that almost all authorities now admit that they were nothing but syphilis. You have besides to settle with Dr. Wallace and his "Morula," and with Dr. Maxwell and his *Framboesia Cromwelliana*.

C. S. I accept them both as Yaws. Is it to be supposed that Dr. Wallace could not diagnose syphilis?

Ego. Is it to be supposed that Cromwell's soldiers, when quartered in Scotch villages, infected their hosts, or perhaps rather hostesses, with a malady known only in the tropics, and not rather with one to which soldiers all over the world are admittedly very liable? As to Dr. Wallace, I have made blunders myself, and, to be candid, I think that when he diagnosed "Morula" in young men and women and cured them all with mercury, he made a mistake in nomenclature. I cannot for a moment doubt that his cases of "morula" were examples of framboesial syphilis. At the risk of seeming to be boastful of my own powers of diagnosis, I may say that in the example of framboesial syphilis in an Englishman (see Plate CLX.) which I published two years ago, so severe was the eruption and so peculiar its appearances that a distinguished authority had refused to recognise it as syphilis. The man, however, had the remains of an indurated chancre still present, and his eruption promptly disappeared under mercury.

C. S. To me a great difference between Yaws and syphilis is that Yaws is much milder. The eruption disappears after a time, and the patient is quite well again. The eruption also, although it looks formidable, leaves no scars, only stains.

Ego. It is a delusion to imagine that syphilis does not disappear spontaneously. In a large majority of cases I believe that, irrespective of treatment, its secondary phenomena would vanish just as do those of Yaws. You seem to forget that there have been anti-mercurialists who have asserted that secondary syphilis disappears just as well or even better when it is not treated as when it is. Then, as to there being no scars, I hold that all framboesial eruptions are attended by growth, not ulceration, and it is always possible for them to wither without leaving scars. Syphilitic

rupia ulcerates and leaves scars, but syphilitic framboesia, whether christened "Morula," "Yaws," or correctly diagnosed, leaves none. There were no scars, but stains only, in the patient whose face is shown in my plate.

C. S. Let me remind you of Charlouis' experiments, and that he found that a patient just well of Yaws was still susceptible of syphilis.

Ego. I am glad you have mentioned that. It is to me by far the strongest fact in support of the old creed of non-identity which can be given. In the main, however, Charlouis' interesting but most unjustifiable experiments favoured the statement that syphilis and Yaws are so closely parallel in their stages and phenomena that, if specifically distinct, they at any rate belong to the same genus. The incubation and exanthem stages are the same, and there is a bubo of the same kind in both. Now, as to the man who was inoculated from a chancre just after his recovery from Yaws, I must allege that it is an isolated fact and was observed by an isolated observer, and we ought not to allow it too much weight until it has been confirmed. Even were it confirmed, I might still urge that second infections of syphilis are not uncommon, and sometimes after very short intervals.

C. S. Well, we must agree to differ, but I am sure we are at one in this in regarding it as a most interesting and important problem.

Ego. Assuredly it concerns the well-being of great numbers. Of this I feel sure, that if, without admitting my contention, those who have to do with Yaws would treat it by very mild but long-continued courses of mercury, they would be doing their patients a great kindness.

CANCER AND THE CANCEROUS PROCESS.

Eczema-Cancer of the Nipple Region in a Man ("Paget's Nipple").

The only example of eczema-cancer of the nipple which I have seen in a man occurred in a patient brought to me by Mr. Woods, æt. 65.

The disease consisted in a patch the size of a large watch-face, which spread from the inner side of the right nipple towards the sternum. It was most abruptly margined, and everywhere its edge presented a low roll of induration arranged in curves. This border was on a very small scale, but quite characteristic. The surrounding skin was quite normal. The surface of the patch was dry, red and excoriated, and did not show anywhere a tendency to resume a healthy condition. It looked like a patch of dry eczema.

The fact which made the diagnosis conclusive was that the patch had been present twelve years, and was slowly advancing at its border. It had given little or no trouble, and nothing special had been done to it. There had never been any eczema near to it or on other parts of the body.

Withering Scirrhus of Breast—Question of Operation.

All surgeons recognise, I believe, a type of cancer in which a tendency to shrivel is very definite. It is most frequently observed in the case of scirrhus of the breast, and its subjects are usually elderly persons, but it is not wholly restricted to any form of malignant disease nor to any age. An instance of it now under my observation offers some peculiarities. When I first saw Mrs. P—— (æt. 69) she had a puckering-in of the skin over her left breast, so that a visible hollow was

produced. At the bottom of this the tissues were felt to be somewhat hardened, but no definite tumour could be detected. Below the mamma, under the skin of the abdomen there was another very definite hollow, caused by shrivelling of the subcutaneous tissues. There was nothing in the least like a tumour under this, but some cords like lymphatics could be felt. The presence of this second puckering made me suspicious that infection from the breast itself had already spread rather widely, and having regard also to the patient's age, I advised that nothing should be done.

I did not see my patient again until eighteen months later. At this time there was quite a definite lump at the bottom of the deep pucker in the breast, and two enlarged glands in the armpit of small size, but quite characteristic. The pucker in the skin of the abdomen was still marked and still free from any suspicion of new growth. The patient being now near 70 and infirm in general health, and the tendency of the scirrhus growth being decidedly towards atrophy, I again advised that no operation should be done.

Cures of Rodent Cancer by Operation followed by independent growths of Cancer in other regions.

Two very good examples of what may be fairly called the permanent cure of rodent cancer by operation have recently come under my observation. In one of these the growth was removed by excision under my advice, but not by my hand, five years ago. The patient, a man of fifty, has now another ulcer of the same kind on the opposite side of his face, but the scar of the operation is perfectly sound. In the second case I destroyed a rodent ulcer on the side of the nose of a lady aged 52, twelve years ago. The scar is now white and soft, and there has never been any indication of tendency to return. The patient, who is also the subject of lupus vulgaris, has now a small fungating growth of epithelial cancer in the middle of her lupus-scar. This is at a great distance from the scar of the rodent. Thus in both these cases we have evidence of the patient's proclivities afforded by the *de novo* development of a second cancer,

whilst the long period of immunity proves that the original operation was in itself complete.

Small growths of Melanotic Sarcoma rapidly inducing extensive Gland Disease.

Case-collectors must often be struck almost with astonishment at the manner in which the features of some peculiar and rare malady are repeated in some subsequent patient. These replicas, or cases which pair one with another, are of great interest and value, since they afford conclusive evidence of pathological law. I reproduce here Plate CIV., which was published in an early number of ARCHIVES, because it serves as an illustration of another case which has just been under my notice. The plate shows a small growth of melanotic sarcoma on the abdominal wall and a mass of glands in the armpit. My second case is its counterpart. The primary growth is on the same region and of the same size, and the glands in armpits are also infected. Fortunately the disease in the latter situation has not progressed so far, and is still well within the reach of surgery. I have of course advised immediate and free excision.

The subject of my second case is a gentleman of sixty. He has been aware for three years past that there was a little black spot on his side, but he does not know of any congenital mole. The latter he may probably have overlooked. When he came to me he thought nothing of the little black growth, and only showed it to me almost casually at the end of a consultation about another malady. He had not recognised any enlarged glands.

It is the apparent insignificance of the primary growth in these cases and the very slight tendency to growth which it displays which makes it so important, by pictorial illustration, to diffuse knowledge respecting them. A growth apparently of no consequence, and perhaps never itself bigger than a bean, may cause rapid and extensive infection of the lymphatics and make the case quite hopeless before any suspicion is excited as to its real nature.

ON HERPETIC STOMATITIS.

CASE I.—*Case of severe Herpetic Stomatitis—Four attacks in six months.*

In the case of Mr. C. B. H——, a schoolboy of seventeen, we had the history of recurring attacks of severe stomatitis without ill health, and without any form of skin disease. When he was brought to me on January 7, 1899, his prolabia were covered with sores and crusts, and in his cheek pouches the mucous membrane was swollen, moulded by pressure against the teeth, and showed recently healed excoriations with white films on their surfaces. His tongue was also swollen, and indented at its borders with filmy fringes. On the frœnum linguæ was a healing ulcer with membrane on it, and on the surface of the tongue and right side of hard palate were healing excoriations. With the exception of the sores on the palate all the lesions were bilateral, and the conditions were those of general but not diffuse stomatitis. On the lips it was the prolabia and not the mucous membrane which suffered. The important question as to diagnosis was whether the stomatitis should be regarded as of herpetic nature.

As regards the question as to herpes, the following facts were in evidence. The lad counted four or five separate attacks, in the intervals of which, as I was assured by Dr. ———, who came with him, the mouth had been absolutely well. No drug had appeared to influence the sores, the disappearance having been apparently spontaneous. The relapses had been sudden and acute, and attended by great soreness. No condition of disturbed health had appeared to attend them.

Arsenic was not one of the drugs which had been tried,

and my advice was that it should be given, and that in case of its failure to prevent the attacks, that a complete change of climate should be made.

CASE II.—Recurring Ulceration of Lips and Soft Palate, probably not Syphilitic.

YEAR.	AGE.	DETAILS.
1889	18	A sore on the lip. It lasted only a fortnight.
1890	19	Recurrences of sores on lip every few months.
1891	20	Still liable to sores on lips.
1892	21	Still liable, but in fair general health.
1893	22	In Ceylon for one year. Had a very bad throat, and was sent home.
1894	23	Returned with his throat bad. It healed during voyage.
1895	24	Saw Dr. D. G—— who thought it syphilis.
1896	25	Liable to recurring sores on lips and in throat. Got nearly well at seaside.
1897	26	It relapsed when he returned from seaside.
1898	27	A sore on scrotum. Sent to me.

The following are the more detailed facts as regards the case displayed in the above schedule. After I had looked into Mr. W——'s mouth and seen the destruction of his soft palate, and the ulcers on his lips, I remarked to him interrogatively, "Of course it is syphilitic?" His reply was, "Well, every doctor that I have seen says so, but I cannot see how it can be, for I never in my life had anything to do with women." "Do you mean literally that you never had intercourse with a woman?" "No, never," he replied, and added, "This disease began when I was 18, and has continued on and off ever since." He was now 23.

Mr. G—— W——, the patient referred to in the

above note, was a pale, thin man, but not specially unhealthy looking. He had lost all his upper front teeth, "punched out at football," but there was nothing suggestive of inherited taint in his physiognomy. He was the fourth of a large family, and said that both parents and all his brothers and sisters were healthy. The condition of throat which had excited my suspicion consisted in extensive cicatrisation of the free border of the soft palate. The remains of the uvula were still to be seen and in middle line, but the edge of the palate stretched tightly across in a straight line. It appeared as if it had been evenly destroyed along its free edge. The mucous membrane of the posterior pharynx was thin and scarred, and low down in the middle line there was a superficial ulcer the size of a shilling, covered with grey secretion. In the soft structures over the juncture of the soft and hard palates there were some sound scars. At the right commissure of the lips there was a white-edged abrasion, and near to it, inside the lip, the scar of a small but deep ulcer. On the prolabium of the lower lip, on the right side there was an abruptly margined ulcer with a grey base, and considerable swelling around its base. This ulcer, I was told, might be taken as a fair specimen of what he had suffered from, from time to time for many years, of what had been indeed his initial symptom. His tongue and the mucous membrane of the cheek pouches, &c., were healthy, but several of his teeth were in a bad state from caries. The only local symptom which he had experienced in addition to those in his mouth was a sore on the scrotum. This, however, had only appeared within the last month. It had now healed, and had left a conspicuous white scar.

The patient's history is displayed year by year in the appended schedule, but it may be summarised by saying that his first symptom, at the age of 18, was a sore on the lip, and that he had been liable to recurring sores on the lips or in the mouth ever since. There did not appear to be any reason for suspecting that the first sore on the lip was a chancre. It was seen by a surgeon, and healed quickly under some local application. It was not, he said,

so bad a sore as many which he had had since, and nothing of the nature of secondary symptoms had followed it. The date of his worst sore throat, that probably which destroyed his soft palate, was at the age of 22, when he was living in Ceylon. He was then very ill, and was sent home in the belief (as he thought) that he would not live. During the voyage home, and irrespective of any special treatment, his throat healed. On another occasion, after a long stay at the seaside, his mouth for a time became quite sound. With these exceptions he had been liable to a repetition of sores on the lips or in the mouth, at least once a month, for the whole of the ten years. Individual ulcers would usually last a week or ten days, but sometimes much longer. In connection with the constant diagnosis of syphilis, he had taken much mercury and iodide, and never with any definite benefit.

A month later, after a trial of iodides, I made the following note :—

“January 3.—My iodide mixture, he thinks, makes his lips, &c., worse. His throat is very peculiar. The uvula is still there, and in the middle line, but the sides of soft palate are symmetrically in state of scar, and tight. There are superficial scars on palate. There are some fresh ulcers on the lips; they are round, punched out, and with grey bases. Herpetic (?). His elder brother comes with him for inspection, and shows no indications of inherited syphilis. Iodoform ointment has done no good. I propose now to try arsenic and small doses of opium.”

Comments.—It must be conceded that in the above narrative the suspicion of syphilis is by no means wholly excluded. The original sore on the lip may have been an infecting chancre, although the account of it given by the patient does not support that view. Whether or not, however, there may have been syphilis in the first instance, we must hold that the type of the stomatitis has been herpetic. The frequent recurrences, the formation of detached and separate ulcers of round form, the resistance to specific treatment, and the spontaneous disappearance upon several occasions, all support this diagnosis.

CASE III.—*Recurring Herpes of the Soft Palate causing scar on one side only.*

Another case which seemed to offer important confirmation of the diagnosis in the above case, which assigned it to the herpetic group, came under my observation not long afterwards. In it the patient, who was a man aged 34, had one half of his soft palate tightened by scar in the manner described above, the other being quite free, and he was undoubtedly the subject of recurring herpes of the throat. When I last saw him (January 20, 1899) the right anterior pillar of his fauces up to its juncture with the posterior at the base of the uvula was somewhat rigid, and showed, when on the stretch, a superficial line of whitish cicatrix. A peculiarity was that this scarring occupied exactly its edge, and did not spread in the least on the surface of the palate. Just above the base of the uvula, but slightly on the right, there remained a single small herpetic ulcer.

Now I had seen Mr. L.— often before for herpes of the palate, and exactly two years ago I had written in my notes: “He has now a well-marked group of herpes-ulcers on the right half of soft palate. This group is now of ten days’ duration, but he says that he has had several similar, and that they come once in two months, in connection, as he thinks, with leaving off mercury.” After the consultation to which this record refers, I prescribed arsenic in weekly alternation with iodide of potassium, and although under these remedies the herpes continued to recur, it was far less severe, and became absolutely painless. He would sometimes show a crop of little ulcers, and yet aver that they caused him no inconvenience whatever. He thought that the iodide did him more good than the arsenic, but really he never gave the latter a fair chance.

The preceding history in this case was that the patient had suffered from syphilis in January of 1894, and had been treated by mercury. His throat had for long previously been “his weak part,” and a year after the syphilis was acquired he became liable to the attacks of herpes of the

right palate as above described. This liability has at the present time lasted four yéars. During the whole of this time he has been in good health, and quite free from other symptoms of syphilis.

It is to be remarked that in this case, as we not unfrequently see in syphilitic herpes, the ulcerations had been much more slow to heal than is usual in the non-specific forms. For herpes which has been long recurrent on the same site to become in the end almost painless is, I believe, not very infrequent. The nerves of the part appear to become exhausted as regards their power of originating and conducting the sense of pain.

In Cases II. and III. above quoted we have examples of contraction of the anterior faucial pillar as a result of frequently recurring herpetic ulceration. In neither was there any account of a severe attack of ulceration such as might have been expected to leave scars, and in both the scar had the peculiarity of involving the edge of the palate only. In both there was clear proof of herpes. In one the conditions were bilateral, in the other strictly confined to one side. In one the herpes began a year after syphilis, but in the other there was no conclusive history of specific disease. A very important suggestion arising out of the cases is, that conditions may be produced by herpes which might easily be deemed conclusive proof of previous syphilis.

DIET AND THERAPEUTICS.

Influence of Antimony in Eczema.

Mrs. N——, a lady of about 30, who had long suffered from eczema, gave me important evidence as to the influence of antimony on her eruption. She consulted me immediately after landing from a long sea voyage, and said that her eruption had persisted for long, and that she had not benefited by her voyage. I prescribed my usual remedies, a tar and lead lotion and tartarised antimony in doses of a sixteenth of a grain.

In a month she was practically well, but she found it necessary to continue the remedies to prevent relapse.

Two months from the beginning and just before her return to the Antipodes, she called on me for final directions. She had then no trace of her eczema, but she still reported that it would return if she left off her remedies. I asked her whether the lotion was not sufficient without the mixture. She assured me that she had tried, and that it was not, and added, “When the eczema threatens my skin feels hot and dry, and a few doses of the mixture make it quite cool again.” She considered that the antimony rather improved her appetite, and said that she had felt quite well whilst taking it regularly for several weeks at a time. Respecting the type of her eczema, it should be added that she had suffered from it severely in infancy, and that the liability had lingered on, probably in connection with an abnormally dry skin. Her hand and fore-arms were the parts most frequently affected.

An acute outbreak of Eczema caused by a few doses of Mercury.

Dr. S——, a tall, spare man, had a midwifery chancre on his finger. It soon healed, and although there was a hard gland in the armpit, he never suspected its true nature until, two months later, a papular eruption and sore throat appeared.

He then prescribed for himself half a grain of grey powder three times a day. From his youth he had been "liable to eczema," but at the time of his syphilis he was quite free. After four or five doses of mercury his hands became hot and painful, and his skin generally hot and dry. He, however, continued the pill two days longer, at the end of which time he had an extensive eczematous eruption. His hands had been in the interval swollen and tense, and so painful that he had been obliged to keep his bed.

About a week after the advent of the eczema, when it was beginning to fade, he came to show it to me. It was then a typical example of eczematous dermatitis. The hands, feet, fore-arms, and face were the parts most severely affected, but a certain number of spots and ill-defined patches occurred on other parts. The symmetry was definite. The affected parts were reddened, slightly moist, and covered with flakes of epidermis. Already the swelling, especially of the hands, was much less than it had been. No mercury had been taken for a week. There were ulcers in the tonsils, and mixed with the general eczema on the abdomen and chest a few syphilitic papules could be recognised.

I advised Dr. S—— to take five grains of iodide of potassium three times a day, to avoid mercury, and use a zinc ointment.

A fortnight later the eczema had almost wholly disappeared, and only a certain amount of desquamation still remained. He could again use his hands.

Dr. S—— told me respecting his former attacks of eczema that they had never approached the present one in severity.

A good cure of Severe and Chronic Eczema-Prurigo
(*"Hebra's Prurigo"*).

In June, 1893, I prescribed for a most severe case of prurigo of five years' duration. It would have ranked as a good example of "Hebra's prurigo" had it not been for the history. Instead of having been present from infancy, it had commenced at the age of 36, previous to which the patient had had a somewhat dry, but otherwise quite healthy, skin. The case had already exhausted the patience of several

specialists, and arsenic had been pushed until the skin was of a deep brown, almost black. My own prognosis was indicated by an expression which I find in my first note, "He will pass into the condition of a Fitz-John case" (the name "Fitz-John" being my designation for a case of pruriginous dermatitis which has proved intractable, in spite of the endeavours of numerous English and European dermatologists). This gloomy prognosis has, however, not been fulfilled. I have just seen the patient again, and have learnt with great pleasure that he has had three years' immunity from his malady. He now comes to me for a trifling relapse wholly confined to the left leg.

As regards the measures under which the cure was effected, my patient is quite clear in his opinion. He says that it was the steady use of the local measures. The prescription was the mixed solution of lead and tar, two parts of liquor plumbi diacetatis to four of liquor carbonis detergens. With this he was directed to sponge all affected parts once or twice a day, to allow it to dry, and then to apply an ointment containing a few grains of calomel. At the same time I prescribed a mixture containing tartarised antimony and aconite. The improvement began as soon as the remedies were commenced, and after a few weeks the mixture was laid aside. Only a small share in the final result can, therefore, be attributed to it. The cure was complete in about fifteen months, during the whole of which time the local measures were steadily used.

Permanency of Cure of Local Gummata.

On September 27, 1890, a gentleman, aged 60, came to me with one of his legs covered with ragged ulcers of syphilitic lupus (a syphilitic form of Bazin's malady). He had five healthy grown-up children, but he acknowledged that he had had syphilis before his marriage ("thirty-five years ago"). He had no other form of tertiary disease, and appeared to be in excellent health. His leg had been bad for ten years. I prescribed iodides and iodoform ointment.

The iodide caused most severe coryza and severe pain in the nose. He was three days in bed with this, but courage-

ously went on with the medicine, and the symptoms passed off and his leg healed. He was delighted with the cure.

In August, 1893, Mr. E—— again came to me, this time for what appeared to be severe tic in his right jaw. He said that he had not slept for a fortnight on account of the pain, and that it would not let him eat. His leg had remained sound. Under full doses of quinine he got rid of his neuralgia, and I saw nothing more of him for five years.

In October, 1898, Mr. E—— came again. He now complained of obstruction of the nostrils, and thought that the bridge of his nose was swollen. There was nothing positive to be made out, but in the right nostril high up there appeared to be a polypoid growth which bled on the slightest touch. There were no enlarged glands. His leg was still perfectly sound, not the slightest relapse having occurred.

Apart from the interest attaching to the nose symptoms, this case affords an interesting example of the complete cure of severe local tertiary syphilis and of the fact that when once completely healed, tertiary ulcerations of this kind show no tendency to recur or relapse. If the cure be incomplete—in other words, if any portion, however small, of the infective cell material be left undestroyed—recurrence is certain.

Deaths after Subcutaneous Injection of Mercury.

I have been informed privately (but with full permission to make the facts known) of a very lamentable occurrence in connection with subcutaneous injection of mercury for the treatment of syphilis. There is a mixture of metallic mercury with oil known as Lambkin's solution, which has had some considerable repute in Army practice, and with which, so far as I am informed, no accidents had been previously known. The surgeon who employed it in the present instance had used it often with good results. On a certain day four soldiers suffering from syphilis were injected with it, no more than the usual dose being employed, and all precautions being observed. Nothing unusual was observed in the solution (which was freshly made), and when it was subsequently examined it appeared to have

been properly mixed. Ten days later the men were injected for a second time from the same preparation. At varying dates, from ten days to a fortnight after the second injection, all became the subjects of the most severe salivation. Ulcers formed in the mouth and throat, and there was in three cases very profuse diarrhoea. Under the combined influence of the diarrhoea and the stomatitis two of them died. Of the two others one is convalescent, and the other still in a somewhat critical state from necrosis of the lower jaw.

Many more or less similar accidents from the injection have, I believe, occurred, and some have been recorded in Continental journals, more especially in Russia. Most of these, if not all, have, however, been isolated, and have been due probably to idiosyncrasy on the part of the recipient. In the present instance, since none who were injected escaped, we may safely assume that there was some defect in the composition of the material used which rendered it more than ordinarily easy of absorption and vigorous in its effects. When once a supply of mercury has been deposited in a patient's tissues there is no expedient short of excision of the part containing it which can prevent its continuous absorption. It is the fact of there being a more or less lasting supply which renders this method of treatment so effectual and at the same time somewhat dangerous. If salivation has been caused by giving mercury by the mouth it can be stopped, and if this be done promptly it will usually suffice to prevent ill consequences. It is obviously not so if one or two large doses have been introduced under the skin and placed out of reach.

Army medical men tell us that it is difficult to induce soldiers to be regular in taking medicines, and hence the favour which the subcutaneous injection plan has obtained with them. In civil practice I cannot conceive of circumstances which should induce us to encounter the risks which that method of treatment clearly involves. The use of mercury in the form of pill is so convenient, and when once the necessary explanations have been made is generally so willingly and so efficiently carried out, that I find it hard to believe that there is any better plan.

ARCHIVES OF SURGERY.

APRIL, 1899.

THE PREVENTION OF LEPROSY.

ON March 9th last a paper on Leprosy was read at the Imperial Institute, in connection with the Indian section of the Society of Arts, by Mr. H. A. Acworth, C.I.E., late Municipal Commissioner to the city of Bombay. I had been invited to take part in the discussion, and the paper which is to follow is a slightly amplified report of what I then said. A full report of Mr. Acworth's paper will be found in the April number of the Journal of the Society of Arts.

I am induced to bring my own statements before my readers because I am very desirous to attract the attention of the profession to the strong and, as it appears to me, unanswerable arguments in support of the fish-hypothesis as to the causation of leprosy. There is nothing new in what I have now to say. I have said it repeatedly during the last quarter of a century, but with only very partial success in attracting attention to the argument.

To my own mind, every time that I review the subject the facts seem to come out in a clearer light, and I am not without hope that I may have succeeded on the present occasion in making their cogency more apparent than I have hitherto done. My readers will, I feel sure, make allowance for the fact that my statements were addressed to a non-professional audience.

Respecting Mr. Acworth's paper, which was the subject of my criticism, it may be said that it concerned itself chiefly with the narration of what had been done in Bombay in founding a leper-home and in preventing, by the aid of the police, the display of their malady by lepers in the streets. The latter object had been accomplished by straining a law as to infectious diseases. No attempt had been made to seek out lepers in their homes and compel them to enter the asylum. The asylum had been well managed and made attractive, and its management had been the means of attracting more than it could receive. At the same time, certain measures for compulsory residence had been taken, such, for instance, as surrounding the place with a barbed-wire fence and, as has been stated, the bringing in by the police of all who openly showed themselves in the streets. Although Mr. Acworth professed to have an open mind as regards contagion, yet he expressed the strongest conviction that the measures that he had adopted would be sufficient to conquer and sweep away the disease. It was against this assumption that I had to protest, whilst expressing warm approval of the institution of homes for lepers and their compulsory exclusion as nuisances from places of public resort.

MR. CHAIRMAN, LADIES AND GENTLEMEN,—None of us can, I feel sure, fail to give to the author of the important paper which we have just heard our hearty applause for the humanity of motive and energy of action which it displays. Without doubt he has set an excellent example and accomplished a very beneficent work. To admit this, and to admit it thankfully and without stint, is still very far from signifying acceptance of his conclusions. Seldom indeed has, I think, a better example of counting chickens before they are hatched been afforded than that given in some of his latter paragraphs. Mr. Acworth feels confident that he has commenced the extermination of leprosy from India, but he has not offered us the slightest proof that he has done anything towards diminishing it. What he aimed at doing was to remove conspicuous lepers

from the streets of Bombay, and this he has accomplished, partly by straining a legal mandate beyond its scope, but chiefly by bringing into play the living law of kindness. He built a leper-house, and made its inmates comfortable and happy, and thus, as he has repeatedly told us, he attracted to it even more than it could accommodate. If, in addition to this, he "fenced it with barbed wire" and employed the police to apprehend vagrant lepers found in the streets, it is yet absurd to call his plan "compulsory isolation" in the sense meant by the sanitarian. His measures were, indeed, directed to the concealment of the leper from sight rather than to the extermination of the disease. For the latter object the leper who lives at home must, according to the theories of the contagionist, be sought out and forcibly removed from those whom his presence endangers. To take into custody only those who obtrude themselves in the public streets is to crop off just a few of the shoots of a shrub whilst leaving its roots undisturbed. The segregation which Mr. Acworth accomplished was kindly and judicious; the measures at which I have hinted are, if not necessary for the public, cruel in the extreme to the individual. I do not believe that they are necessary, nor that, however rigidly carried out, they would exercise the slightest influence on the prevalence of leprosy. They would leave its cause wholly untouched. In saying this, let me say again that what Mr. Acworth did has my warm approval. I dissent only from his assertions as to what he thinks he was doing. There is no inconsistency in being an advocate for Leper Asylums and at the same time a disbeliever in contagion. I am "Christian Socialist" enough to hold that it is the duty of the State to provide for the maintenance and comfort of all who by misfortune are disabled from earning their own living, and I see nothing at all unjust in a community declaring that it will not permit loathsome exhibitions of disease in its streets. In these respects the leper and the victim of any other disabling and disgustingly disfiguring malady should be treated alike.

In most parts of Mr. Acworth's paper there is a tone of most judicious moderation and of very evident desire to avoid exaggerations. This is shown in his statements of the

number of lepers in India and in Bombay, and in some of his references to the fallacies of statistics. We may thank him for not having attempted to construct any statistics of his own, and if he has been—as I think he has—misled by those sent us from Norway, it is not a matter for surprise. Permit me to say a few words about these with the object of showing that they do not prove what they are supposed to do. Leprosy at one time prevailed extensively all over Europe, including the British Isles. In the latter it lingered last in the Shetlands. It disappeared from amongst us by slow degrees, *pari passu* with the advance of agriculture, and it is not more than a century since the last case occurred in the Shetlands. During the period of its decline it attracted but little attention, and all measures of isolation ceased to be observed. Now when it died out in our northern islands, it still lingered on the opposite coast of Norway and in Iceland. The parts of Norway in which it still persisted were chiefly those on the west coast, with Bergen and Molde for their centres, the homes of the fishing industry, and the homes in another sense of a population steeped in poverty and almost wholly without agricultural land. They had participated but little in the general advance in social comfort made in more favoured regions, and they were still largely dependent upon fish as food. Yet there is reason to believe that for long leprosy has been slowly on the decline in Norway. That it has declined more rapidly in the last fifty years we may thankfully admit. Norway has become a pleasure ground for tourists, and wealth and comfort have increased, and precisely those conditions have prevailed before which, in all other temperate countries professing the Protestant religion, leprosy has always yielded ground. To claim the recent diminution of the disease as being attributable to segregation is to ignore the experience of other countries. Leprosy was common in New Zealand during the early period of our colonisation, but with the advance of agriculture and the diminution of fishing it has disappeared without any aid whatever from attempts at segregation. As to segregation in Norway, the truth is that it has been of very recent introduction, and only to a very

partial extent. The disease was rapidly diminishing before the new law was enacted, and at a time when lepers were frequently to be seen in the streets of Bergen. When the new law was passed it was not necessary to provide any additional accommodation, for what existed was quite enough. It may be plausibly held that the new law has been merely coincident with the decline of the malady from other causes, and that to boast of its results is to imitate the fly on the coach-wheel. Mr. Acworth has told us that to him it appears the merest "trifling" to argue that the three hundred millions of India's populations must wait for the extinction of leprosy until it is brought about by "the general improvement of physical conditions and sanitary surroundings." Surely it is not necessary to remind him that if such improvement be the one means to that end, he will have to wait. The forces of nature are inexorable, and we shall do well to study them patiently, and not to rush in ignorant haste upon useless expedients.

Leprosy has disappeared from a thousand of its old-world haunts, and it has done so under the influence of precisely those changes which we are now told it is "mere trifling" to wait for. I hope soon to show that even in reference to them it is not necessary to wait inactively, and that there are measures which may be adopted promptly and with great hope of success. Cruel and barbarous in the extreme have been the measures which in the past have been resorted to for the extermination of leprosy. Permit me to record my conviction—a conviction resulting from a lifelong study of the subject—that those measures have never contributed in the least to the end desired, and that that end has been meanwhile slowly brought about by the very influences which are now spoken of so disparagingly. I will now try to show that the extirpation of leprosy by natural measures—by such, I mean, as aim at removing its cause—is not perhaps so hopeless as some have imagined. The data exists which should enable us to form a confident opinion as to the nature of its cause, and it is not one which is irremediable. Of these data the non-medical mind is almost as well capable of judging as the trained physician, and it is much to be

desired that the general public should look at the facts for itself. Surely it does not require much medical knowledge to appreciate the bearing of some of the facts which I will now mention.

Leprosy is identically the same disease in Iceland, Norway, the Sandwich Islands, the East and West Indies. *Inference*, that it has nothing whatever to do with race or climate.

Leprosy affects the rich as well as the poor, and may develop itself in Europeans who go to live in leprosy districts, and it is in the army officer or the missionary precisely the same disease as in the poorest native. *Inference*, it has no necessary connection with poverty or personal neglect.

Leprosy prevails extensively in some places—as for instance, the Sandwich Islands—in which as regards food, clothing, and climate no sort of hardship exists.

In leper asylums the doctors, nurses, and servants never contract the disease. *Inference*, it is not contagious.

When lepers are imported into countries where the disease does not prevail, as, for instance, from Norway into the United States, they never communicate the disease to others. *Inference*—it is not contagious. In further confirmation of the last proposition it may be stated that no year passes without the introduction into England of a certain number of lepers (Englishmen who have developed the disease abroad). In all the nature of the malady is carefully concealed, and they mix with their friends without any special precautions. No single instance of any suspicion of contagion has occurred.

I have on the table before me a Globe on which I have endeavoured to mark the districts at present the homes of leprosy. The lessons of this globe are most instructive, but I must not venture to speak of them excepting in the most general terms. You will find that there are black marks on the seaboard of almost all well-populated countries. The chief exceptions are parts of Europe, the British Isles, and the United States. At many of the spots marked, however, there are but few lepers, not more perhaps than might be counted on the two hands. These few have in most such instances had their representatives for many generations, and although no segregation, as a rule, is attempted, their

number does not increase. I ask, does this look like contagion? In many other places, however, Japan, China, the Malay peninsula, India, Ceylon, the West Indies, parts of South America, the Sandwich Islands, I have been obliged to use the brush very freely. In most of these, however, although the number is large, there is reason to believe that it is either stationary or declining. Were it capable of spreading by contagion we should—since the precautions taken are, in most places, of the weakest possible kind—expect it to attain universal prevalence. Surely it does not need a medical education in order to see that a disease which affects half a dozen people at fifty different places on the shores of the Baltic, another half-dozen in New Brunswick, and a few more in Crete, and which never spreads, has far closer analogy with the dietetic diseases such as gout, than with a contagious one such as small-pox. Just as gout prevails in certain districts amongst certain classes and in certain families, and does not spread, so it is with leprosy. The legitimate inference is that both are dietetic diseases, and the legitimate hope is that as gout is yielding before tea, coffee, and temperance, so will leprosy yield before the substitution of cereals, potatoes, and butcher's meat for salted fish.

Another argument of great cogency is, I think, fairly obtainable from examination of the Leprosy Globe now before us, when it is explained that in nearly all the places where the disease prevails now it has done so from time immemorial. It is not the fact that European influx introduced leprosy to aboriginal populations, as has been the case with many other maladies. Everywhere we found it there already, and everywhere the same. Go where you will, Japan, China, Borneo, Sumatra, New Zealand, the East and West Indies, everywhere, provided you keep near the coast and amongst races which have learned the art of fishing, and there you will find reason to believe that leprosy has existed from the most ancient times. Quite recently in the Fiji Islands "Leprosy Stones," regarded with superstitious reverence, have been found in many districts (Dr. Corney). I do not see why it should be held to demand the acumen of a physician to determine the bearing of this remarkable fact. If a disease

is found to be one to which the whole human race, when residing in certain districts and adopting certain habits, has from all time been liable to suffer, and if that disease is found to prevail independently in countries—*islands*, as well as *continents*—which through long ages have had no communication with each other, does it not follow that it is a malady capable, so to speak, of spontaneous origin? Is it not proved almost to demonstration that it cannot owe its origin to contagion, but must rather take its rise in some usage common to the human family?

No single usage can, I affirm, be suggested, which does not concern an article of food. In this matter I am half inclined to make appeal to the intelligence of the public against the prepossessions of my own profession. I shall be told by the latter that it is absurd to compare leprosy with gout, because in the one there is a bacillus and in the other none, and that when a bacillus is present the malady can be none other than contagious. The medical mind is at present engrossed by the study of microscopic organisms, and is dazzled by the flood of new light which has beamed upon us respecting them. In a little time we shall see more clearly, and I much mistake if we shall not then come to recognise that these organisms are modified by their food, and that in many diseases their development denotes only a stage in the causation. To say that because bacilli are present, therefore a disease must be contagious and contagious only (whether it be done in the case of tuberculosis or of leprosy) is, I cannot but think, to go far beyond what has been proved. Mr. Acworth would probably call it a slavish regard for logic; I would myself rather say that it is a lapse of logic, since it rushes to an inference before it has been ascertained that the premises are true. The tubercle bacillus may be in latent forms ubiquitous, and may take its energy and its special forms of development from the food with which it is supplied.

There is nothing that I know of that has been proved in reference to the life history of these low organisms to discredit such an hypothesis, and very much in its favour. For the present, however, it will probably be caviare to most of our zealous bacteriologists, and for that reason I venture to

think that intelligent lookers-on are entitled to form their own opinions.

The fish-hypothesis covers well, I believe, the facts as to the prevalence of leprosy in all parts of the world with the exception of certain districts in India. In many the evidence in its support is very strong indeed. Respecting certain inland districts of India which suffer, I well know that I shall be assured that fish is not to be had, and that if it were obtainable the religion of the race forbids its use. To this I am able to reply that the evidence which has been given me by those who have resided in those districts has been most contradictory, and that I have been assured by many who had good right to give opinions that nowhere in India is fish food inaccessible, and that amongst no classes does religious prohibition wholly avail to exclude it; and further, that the statements made by the natives as to their dietetic habits are absolutely untrustworthy. The fish-theory does not imply a large consumption of fish, but rather the use—it may be in only small quantities—of very deleterious kinds. From such use I do not believe that any district or any race in India is wholly exempt. Further, it may be added that the degree of prevalence is almost always in ratio with what is probable as to the use of fish. Where fish is reputed to be unobtainable there is but little leprosy, and *vice versa*.

By all means let us have leper-homes, but let us abstain as much as possible from resort to the policeman and barbed wire, and conduct them rather on the principle of the farmer who tethers his flock by their teeth. Make the homes comfortable and attractive, and the poor creatures will gladly resort to them. Any legislation which purposes to deal with leprosy as a contagious disease, and to enforce isolation on that pretext, deserves, I must contend, the strenuous opposition of all who are well informed as to the details of the subject. On the other hand, legislation would be well warranted which should restrain as being “unfit for human consumption” the fabrication and use of certain articles of fish-food now common in India. It would be justified on the plea that it would strike at the real cause of leprosy,

diminish the terrible sufferings it produces, and in time do away altogether with the need for leper-homes.

That I may if possible avoid the risk of being tedious, let me hasten to avow my own conclusions. The chief of them is this, that if a malady has been proved to be almost universally prevalent; to pay no regard to climate or to race, to riches or to poverty; and to be at the same time neither hereditary nor for practical purposes contagious, there is but one inference possible, and that is, that it must be caused by some article of food.

I defy any one to accept these propositions and to arrive at any other explanation of the facts. My next conclusion is that there is but one article of food which can be plausibly suspected as the cause of leprosy, and that is *uncooked fish*. Again, I defy any one accepting the food-hypothesis to mention any other article. Just as we may be quite sure that it is no telluric or climatic influence which causes leprosy, because the disease prevails in districts which vary widely as to these; so we may be sure that it is neither flesh of pigs, rancid butter, or any kind of vegetable, for we find leprosy amongst peoples who vary exceedingly as to their use of all these. On the other hand, as regards uncooked fish, the evidence is *primâ facie* overwhelming. In almost every district where leprosy prevails, fish has been suspected. The disease prevailed most in aboriginal communities and in times when fish was extensively used; it prevails still in large fishing centres and along sea coasts. Excepting under special conditions, it is unknown in inland districts. One of the most recent writers on the subject (Dr. Ehlers), speaking of its present distribution in Europe, has used the expression, "it forms, roughly speaking, a ring round the continent." It has disappeared from numberless places simultaneously with the progress of agriculture and the substitution of other forms of food for fish. It rose in Europe to its highest point when the supremacy of the Roman Catholic Church—with its numerous fish fasts—was at its height (in the time of Hildebrand), and was coincident with a low state of agriculture. It began to decline, it is true, before the days of the Reformation, but the rate of decline was apparently very much

helped by that event. It still apparently, so far as Europe is concerned, has a great predilection for Catholic communities. It did not follow the Greek Church into Central Russia, and it does not occur there now, for that church forbids the use of fish as well as of flesh on its fast days. In recent years it has increased largely in the Sandwich Islands and at the Cape, and in each place coincidentally with the establishment of a company for salting and drying fish. I have already dealt with a difficulty which is alleged in respect to the fish-hypothesis which, if it were based on fact, would be fatal to it. It is asserted that some communities in India and many individuals suffer from leprosy who have never eaten fish. For the present I must be permitted to repeat my entire incredulity on this point, and to add that my scepticism is based on much investigation.

Mr. Acworth has spoken eulogistically of Dr. Vandyke Carter, because, as is asserted, his practice and his opinions were inconsistent, and has said that he was "the master of logic, and not its slave." I am not so stupid as not to see that there is something epigrammatic in this expression, but I yet cannot appreciate its force. Most willingly would I be, if I might, the slave of logic, and deeply should I suspect the correctness of my opinions if I could not base my practice upon them.

The leprosy question has above all others suffered from this masterful disregard of logical thought. Surely it is not in accordance with either logic or common sense to go on asserting that the disease spreads by contagion when the evidence is overwhelming in the opposite direction. Nor is it logical—and if not logical, is it wise?—to continue to act as if the disease were in some direct association with poverty and neglect, when it has been shown that the rich and cleanly suffer in precisely the same manner as the dirty and the poor. Nor is it logical to go on repeating, and trying to support by reference to authorities, statements which have been refuted over and over again by reference to facts. I understand by logic the application of sound reasoning processes to the subject in hand, and although it is very certain that nothing like "mathematical demonstration"

can be obtained in that with which we are now dealing, yet I feel sure that those who are weak enough to let their prejudices and prepossessions override the conclusions obtained by the careful investigation of facts, will never arrive at the truth.

My own theory as regards the nature of leprosy is that it is a malady closely allied to tuberculosis. Its bacillus is one which can hardly be distinguished from that of tubercle, and the two diseases touch at more points than one. It might probably be termed *Fish-eater's tuberculosis*; such name being allowed to imply that the bacillus of tubercle is in the leper modified by fish-food. The remedy which I would propose is an inexpensive one, and would not in any way curtail the food of the community. It would be simply to prevail upon those living in leprosy districts never to partake of partially raw or decomposed fish. At the same time that no effort should be spared to diffuse information and to secure change of habits in this matter, it is very desirable that leper asylums should be founded wherever there are lepers. It should, however, be clearly understood that they are solely for the benefit of the leper, and that they make no pretence to the extermination of leprosy. To suggest that they will have any efficacy in the latter direction, and to base such suggestion on the creed that the disease spreads by contagion, is to proceed on a false hypothesis, and can only lead to disappointment.

The true friends of the leper are those who conscientiously seek to discover the cause of his disease and to remove it.

In conclusion, I have but to repeat what was said at the outset, that I feel most grateful to the author of this paper for a most praiseworthy example of energetic benevolence, whilst at the same time I cannot agree with him in thinking that the measures he advocates would produce the results which he desires.

AN UNUSUAL FORM OF SPASTIC CRAMP.

In the following case very curious nervous attacks occurred apparently in connection with functional disturbance of the liver. The patient had recently suffered from syphilis, but his liability to the attacks which constitute the principal feature of interest in his case began before his syphilis. These attacks were subsequently accompanied by very deep transverse furrows in his nails, and on two occasions by almost complete loss of scalp-hair, which soon grew again as well as before. The furrows in the nails and the loss of hair had possibly not occurred before he had syphilis.

The appended schedule shows the sequence of his disorders in chronological order.

YEAR.	AGE.	DETAILS.
1887	16	Became liable to "liver attacks."
1888	17	Bilious at times, but not otherwise ill.
1889	18	" " " "
1890	19	Severe influenza left him prone to "cramp."
1891	20	Liable to cramp and unable to do anything.
1892	21	Still liable, and unable to follow his occupation.
1893	22	Consulted Sir J. Russell Reynolds and recovered.
1894	23	In South Africa and in good health.
1895	24	" " " "
1896	25	Syphilis (complete), January. Mercurial treatment. Loss of hair.
1897	26	Mercury. Hair grown "too thick." Nails first affected.
1898	27	Liable to "attacks of bile," and after one again lost his hair.
1899	28	March. See last note, page 114.

A chief feature of interest in the case concerns the precise nature of the attacks which the patient described. He considered them "liver attacks," and he described his sensations as "cramp." His "cramp," however, was not a painful contraction of muscles, but a temporary stiffness and inability to use them. Had he been a nervous young woman, his description of his feelings might have been thought fanciful and attributed to hysteria. He was, however, a robust man, not in the least nervous, and the deep furrows which were left in his finger-nails were irrefutable evidence that his attacks were attended by very important disturbances in circulation. That he was not the subject of any serious organic disease was rendered clear by the fact that he enjoyed perfectly good health in the intervals of his "liver attacks."

On one occasion his attack had appeared to threaten paraplegia, and a physician whom he consulted ordered him at once into a home for treatment under that diagnosis. At the time he was unable to walk without assistance, but in the course of a few days the whole of the symptoms had cleared off. No jaundice had ever been observed, nor were the attacks attended by some of the more ordinary symptoms of sick-headache, yet my impression is that the patient was quite right in his supposition that they were of liver causation. The kind of disturbance which is in many persons attended by migraine and sick-headache is probably capable of wide deviation from type, the essence of it being an arrest of function on the part of the liver.

With such arrest may be associated a great variety of reflex phenomena, part of them, no doubt, concerning the distribution of the blood, and being attended by arterial ischæmia. It is by reference to some such hypothesis, I think, that we must seek to explain the production of the deep transverse furrows in the nails which occurred in this case—such as in others follow typhus fever, pneumonia, and the like.

My notes of Mr. P——'s case have been taken in a somewhat fragmentary way, but in order that I may avoid any risk of error, I think it will be better to offer to my

readers these fragments as they were written down at the time. Here and there possibly some slight discrepancies may be detected, but the picture as a whole will, I think, be more truthful than if I were to attempt to epitomise them.

Although Mr. P—— came under my care on account of specific disease, and we must consider that his symptoms were from that date complicated by the latter, yet it was certain that they were not wholly due to it. He had suffered from the attacks which are now to be described long before, and he had been under the care of several physicians, amongst others of the late Sir J. Russell Reynolds. He did not consider that he had been specially bilious when a boy, but he had begun to suffer during the adolescent period and had been much worse after an attack of influenza in 1890. After this a two years' illness quite disabled him. As a boy he had perfect health and no headaches. His father, he said, "considered himself very bilious and was frequently taking medicine."

Mr. P—— himself had of late years (that is, since his recovery from the illness referred to) regarded himself as very fortunate if he got through six weeks without a liver attack, and all his liver attacks were attended by what he called "cramps," meaning by this expression stiffness of his muscles generally, but without pain or spasmodic contraction of any. He said that during these attacks he could not walk about, nor take any interest in anything. Sometimes stiffness of a limb would be brought on by an effort to use it. Thus, in taking up a poker, his hand would sometimes grasp it firmly, but he would be quite unable to do anything with it. In attempting to mount a horse, the effort of putting one leg to the stirrup would render the other quite stiff, so that he would be quite unable to throw it over the saddle. If he stooped down, his back became stiff and he could not rise. The period of worst liability to cramp had been the two years following the attack of influenza. More recently he had been to a large extent free from them. His partial recovery was in 1893, under treatment by mercurial pills and whilst being made to walk ten miles a day. He said that the cramp during the

worst time had frequently affected the muscles of his eyes, and fixed the latter in his head. He had also then been liable to "cramp of the scalp." The muscles of his chest and tongue had also often been affected so that he could not speak and could only breathe with difficulty. The liability to these attacks would usually last over several days together, and then pass completely away. During one of the worst he had had double vision. When they were present, if he kept a limb in one position for any time it became stiff and rigid, and he was obliged to move it or change his position in order to get rid of a somewhat painful sense of contraction. He said that the attacks of numbness in his hands were not, as far as he had observed, attended by coldness. The hand remained warm but felt dead, as if frozen. The attacks were attended by great depression of spirits, and a feeling as if he could hardly crawl about. In spite of his liability in these respects he had recently led an active life, and had been through the native war in Buluwayo. During the years 1891-2, however, he suffered so much from the attacks of cramp that he was disabled from all occupation and under constant medical care.

The above statements refer to his experience before I saw him, and before his specific disease. For the latter he came under my care in October, 1896, the date of its commencement having been February of the same year. In July of that year, whilst the secondary phenomena were fully out, he had had a severe illness which had kept him in bed two or three weeks, and during which he could not walk on account of the liability to his so-called "cramp." He was at this time so weak that he had to be supported by two men when he attempted to stand. After this attack he lost his hair and his nails, and from this period probably dates the liability of his nails to become furrowed during the attacks. At any rate, according to his observation it had never occurred before. He remained under my observation and under specific treatment from October, 1896, to the present date, March, 1899, and the following detached notes record his progress. At the time that he came to me he was almost bald and his nails were very deeply furrowed.

Feb. 10, 1897.—He has continued my mercurial pills regularly, six or seven a day. No symptoms whatever. Nails as before. He says that he has had much less cramp since he has been under treatment for syphilis. He still gets threatenings of attacks if he takes too much whisky. The pupils are of normal size, and act, but only very slowly.

April 14.—He has relapsed, and has again had cramp. He had ridden twenty-five miles on a bicycle, and had to stop because he could not breathe. He waited a while, and his hands and arms became stiff. He got warmed and rode a few miles further and took some food, but he could not see properly. This was six weeks ago, and his nails show again deep furrows as its result.

Sept. 30.—His little and ring fingers on both hands are now quite sound; but they used to suffer. The nails of the other three on both hands show deep transverse furrows, and are much discoloured. The condition is absolutely symmetrical. He has played much tennis and has done athletics, and once ruptured (partly) one tendo Achillis. He thinks that a severe liver attack "stops his nails growing." His liver attacks are attended by great depression. During these attacks his fingers feel numb and lifeless. He complains of noseache, as if he wished to press it. No double vision of late.

He takes Hydr. cm. Cret. gr. i. six a day.

August, 1898.—Six weeks ago an illness began which he called "liver," and which lasted ten days. He was not yellow. He had cramps and felt ill, but did not keep his bed. After this he again lost his hair and his nails were furrowed. His nails now show the deepest transverse furrows I have ever seen. The nails affected are thumb, index, and middle; the ring and little are very slightly marked. The nails are very hard and the furrows deep enough to lay a probe in. The furrowing begins at the lunula. During his "attacks" he loses all energy and can do nothing. His finger-tips feel dead and numb. He tries to get about his occupation, and does not lose his appetite. His stools become slaty grey and the urine is often red and cloudy. His complexion is a yellow brown. "When I have liver I cannot use my limbs well." His hands feel heavy and big, and sometimes he can scarcely button anything and has to use one hand to move the other. His last attack was brought on, he thinks, by work in the hayfield in hot weather, but he was taking beer.

He gets "cramp" in any limb if he puts it in an unusual position. This "cramp" is a sense of stiffness without much pain, but with a sense of disability. He is obliged to move the part in order to get rid of it. It may affect his tongue, and he becomes unable to speak. His manoeuvre then is to lift up the floor of his mouth from outside by his thumbs. He has now been liable to these cramps for nine or ten years.

When free from his liver attacks he feels well and as bright as ever, but says, "I am lucky if I can get over a month without a relapse, and I habitually take liver pills if I feel an attack threatened."

His father is bilious, but not his brothers or sisters.

Oct. 18, 1898.—He is still liable to liver attacks, and thinks that my pills do not prevent them. He has, however, had no serious attacks

His little and ring fingers have smooth nails. The thumb, fore, and middle fingers show each two deep transverse furrows. His nails are thick and hard, and consequently these furrows are deep and conspicuous. He himself says that these furrows record the occurrence of liver attacks. Formerly his little and ring fingers used to become furrowed; now they are only pin-pricked—that is, very slightly marked. He is now abstinent as regards alcohol.

His last severe bilious attack was on August 10th. He was not laid up, but felt as if he could not walk about or take interest in anything.

He has a conjunctival ecchymosis on the outer side of the left eye, and complains of painful aching around the orbit. He is liable to constipation and has pale fæces. The nails of the great toes show the same transverse furrows as do his fingers.

Mr. P—— was good enough to attend at one of my Demonstrations on February 15, 1899, when we observed some fresh points as to his nails. They were at this date very deeply marked by transverse furrows. We observed that these furrows were deepest in his thumb nails, and that they were rather better marked in all the digits of the right than in those of the left hand. The bilateral symmetry was, however, well marked; it was simply a question of degree. In both hands the two ulnar fingers were but very slightly affected. In the right ring-finger the lowest of the transverse furrows was substituted by a narrow band of white. The whiteness was evidently the same in character as that which produces the common white specks in nails—that is, opacity of the nail structure. In place of a speck or spot, however, there was a band which ran across the nail from side to side. It was exactly on a level with the lowest furrow in the other nails—that is, about midway between the root and the free edge. This white band was slightly indicated in the little finger of the same hand and also in both ring and little fingers of the other hand.

Mr. P—— again gave us a graphic account of his “liver attacks,” the results of which were chronicled on his nails. He said that they were never attended by headache, but only by a dazed feeling; that they never produced sickness nor even took away his appetite for food. He could, he assured us, always eat, but he entirely lost his desire for tobacco and also for stimulants, although his mouth was

clammy. The attacks began by a dazed feeling of inability for exertion, and would last a few days if he did not take opening medicine. They were always accompanied by constipation, and, he thought, always cut short by free action of the bowels.

Mr. P——'s last visit to me was on April 10th. He was then in good general health, stout and strong, and had no remaining symptoms of syphilis. His nails were almost smooth, and during the last two months he had had only very slight attacks of "liver" or "cramp." I was inclined to claim his freedom from the latter for the mercury which he had taken, but he was not willing to admit this, and said that he had been better since he left it off. There was no doubt that he was always more free from attacks when wholly abstinent as regards stimulants, and when taking regular exercise in moderation. Any excess was prone to put him wrong.

PEMPHIGUS AND ITS VARIANTS.

(Continued from Vol. IX., page 32.)

Much of what I have written in my recent papers on pemphigus and its variants has been designed to discover, if possible, the true nature of these maladies and to assign their real causes. In this attempt it has been necessary to go into considerable detail in the record of cases, more especially in the examination of their earliest stages. Two or three conclusions may, I think, be said to have been satisfactorily arrived at: First, that many pemphigoid forms of dermatitis owe their being to a congenital peculiarity in the structure of the skin which favours the separation of the epidermis by the effusion of fluid under it. Second, that the influence of the nervous system is sometimes definite, the eruption being preceded by, or attended with, manifestations which are allied to herpes. Thirdly, that the eruption itself tends, either by blood poisoning or influence on the nervous system, or both, to perpetuate itself and to increase its own severity. These several elements of causation may be very variously proportioned in different cases, but are probably present together more or less in all.

I have at this time, in continuation of the subject, to record a few more facts, to which what has just been said may serve as an introduction.

A local patch of Pruriginous Erythema, followed in third month by Dermatitis Maligna of Pemphigoid type—Acute course—History of life-long liability to sore throats, possibly of an Herpetic character.

A principal feature of interest in the following narrative is that it records in some detail the introductory stages of a malady which we seldom see until it is fully developed. We have a local patch of dermatitis, apparently very insignifi-

cant, serving as the precursor of an acute and general pemphigus. There are also some facts as to the patient's antecedent liabilities which may be of importance.

MONTH.	WEEK.	DETAILS.
April	First Week.	A patch of redness on outer side of thigh.
April	Second Week.	The patch itched, but did not cause her much annoyance.
May	Third Week.	The patch continued and extended gradually.
May	Fourth Week.	The patch was still extending.
May	Fifth Week.	The patch was exceedingly irritable, and she scratched it constantly.
May	Sixth Week.	The patch persisted and extended at its edges.
June	Seventh Week.	
June	Eighth Week.	
June	Ninth Week.	
June	Tenth Week.	The patch of erythema on the thigh had become larger than the hand, and had begun "to blister on its surface."
July	Eleventh Week.	
July	Twelfth Week.	
July	Thirteenth Week.	20th. I saw Mrs. F. for first time. Alk. aperient mixture and carbolic acid had been used.
July	Fourteenth Week.	29th. Some spots on chest appearing. Mercury and iodide ordered.
August	Fifteenth Week.	Mercury and iodide continued. Eruption increasing and spreading over whole surface.
August	Sixteenth Week.	14th. Arsenic with mercury ordered. The eruption advancing rapidly.
August	Seventeenth Week.	Comes to me a second time. (See additional notes.) Pemphigus eruption abundant.

Additional Notes.

Mrs. F—— described her eruption as having begun on the outer part of her left thigh as “a red and hot patch.” It remained small for two months, and then began to spread. At this time there was no blister. It was quite quiet, and used to shed white scales. She took no notice of it, and did not consult any doctor. Five weeks ago she first consulted Dr. S——, and at that time she had only the patch on the thigh, but it was “beginning to blister.” It was then called “acute eczema.”

Mrs. F—— further told me that she had since girlhood been liable to “sore throats with little blisters.” A year ago last Easter she had a very bad throat, and had to get advice for it. It lasted more than a month. It was a painful throat which prevented her from swallowing. All the winter she had a deep crack in the middle of her lower lip, which used to bleed, and which has indeed only just healed with a deep, narrow scar. Her mother had died of phthisis. None of her brothers or sisters were liable to skin disease. Her mouth and throat when she came to me showed nothing particular, but were very pale. She was always regular.

Case of so-called “Hydroa.”—Negative result of specific treatment, but gradual recovery after nearly a year’s duration—No relapse during five subsequent years.

The following case is one in which a bullous eruption of formidable character developed in a man of intemperate habits who had suffered from syphilis. It was called “Hydroa” by one specialist; dermatitis herpetiformis by another; and pemphigus by a third. There were no sores in the mouth. It did not yield in a definite way to either arsenic, iodides, mercury, or opium, although repeatedly it was almost well. It was attended by intense itching. After several partial recoveries and relapses it finally disappeared, leaving the skin much stained. It had lasted altogether nearly a year. It was impossible to say to what influence the recovery was finally due, but not improbably opium had the largest share. After the eruption had quite ceased there was no relapse, although the patient continued to indulge in habits of intemperance. He still had some eruption in his beard, which was diagnosed as syphilitic eczema, and for which he was accustomed to take iodide of potassium. I myself saw the patient on one occasion only; his subsequent

history was very courteously supplied to me by his surgeon, under whose observation he has remained to the present time. In spite of the fact that my friend declared himself unable to say what had cured his patient, I have no doubt

AGE.	DATE.	DETAILS.
35	1888	October. A chancre followed by eruption. Had mercurial baths. Could bear mercury well and was never affected.
36	1889	Fairly well, but occasionally taking medicine. Living very freely as regards stimulants.
37	1890	Fairly well and free (almost) from reminders.
38	1891	Was fairly well, but liable to some syphilitic eczema in beard; used to take iodide now and then.
39	1892	May. The "Hydroa" began. After a great variety of treatment by many specialists, during which nothing appeared to do definite good, he much improved. The hydroa has relapsed after a fortnight, during which he was almost well. (Brought to me in October.)
40	1893	No treatment had any special influence. Mercury, iodides, and opium were used. After about a year's duration the eruption gradually ceased.
41	1894	Covered with brown stains, but no recurrence of eruption. Still intemperate, and nervous in consequence.
42	1895	Although still intemperate and sometimes on the verge of delirium tremens, he had no relapse of his eruption. Still liable to eczema in the beard.
43	1896	The same. If alcohol could have produced the eruption it had a fair chance.
44	1897	The same. Free from any tendency to relapse.

that the drugs are to be credited with the result. I never saw such an eruption disappear spontaneously. It is not very uncommon for pemphigus to resist arsenic and opium for some time and to yield at last. Sometimes the recovery progresses and is concluded after the drugs have been left off. Such was the course of events both in Dr. Clement Dukes' case and that under Dr. Stephen Mackenzie (see Vol. I., p. 59 and Plate 38).

Additional Memoranda.

October 8, 1892 (date of consultation).—*Description of patient's state:* He is now covered with the brown stains of his hydroa on abdomen, below navel, on back at same position, in buttocks, thighs, and legs, and on forearms. He has only been a few weeks well, and indeed has never been quite so. The eruption has avoided his chest, upper part of abdomen, and upper part of back.

The eruption is almost symmetrical. It consists of erythematous patches which vesicate at their borders and spread. They are attended by some thickening and form crusts. Some of the bullæ are quite as large as those usually diagnosed as pemphigus, and excepting in their tendency to spread at the edges and fall down in their centres, I see little to distinguish it from common pemphigus. Mr. Ll. W——, who brought him to me, told me that he had seen "some blebs almost as far across as a teacup."

Cure of Pemphigus apparently complete after many severe relapses—Long-continued use of Arsenic.

It is very important in order to complete our knowledge of what pemphigoid dermatitis implies that our cases should be followed up. A cure by arsenic may be only temporary. Not a few of the cases which I have recorded have tended to prove that there is a very marked liability to relapse, and that sometimes after prolonged intervals of good health.

I have just now the opportunity of adding four years to the narrative of one of the cases which I have published. Mrs. C—— is now aged 60, and it is ten years since I first prescribed for her pemphigus. It was severe, and more than once her death was expected. Arsenic, however, always controlled it, and she took the drug with intermissions for many years. On February 25, 1898, Mrs. C—— came to bring one of her friends to me, and I had the pleasure of

learning that she was in good health, and had for nearly four years been quite free from eruption. Her last attack occurred under somewhat unusual circumstances. She had fallen and sprained her ankle, and a relapse followed the shock.

Mrs. C—— called on me again in April, 1899, to bring one of her daughters. The girl, aged 25, is the subject of neuroses with Raynaud's phenomena and much want of tone, but has had no skin disease. Mrs. C—— herself is in excellent health. She is now 61 years of age. She has had no relapse of her pemphigus for several years, but she tells me that she is liable to a sort of threatening attended by burning and irritation of the skin. This, however, always passes off without producing vesication. I believe that she has of late taken no arsenic, but only nux vomica.

DATE.	AGE.	DETAILS.
1883	45	Brought to me with severe pemphigus of six months' duration.
1884	46	Taking arsenic irregularly.
1885	47	Still liable to relapses, and taking arsenic.
1886	48	Under Dr. Payne in St. Thomas' Hospital, and cured for a time.
1887	49	Relapses.
1888	50	A relapse in July. Face and abdomen severely affected. Soon arrested by arsenic.
1889	51	Taking arsenic almost continually.
1890	52	Has been well for the most part. A few vesicles occasionally.
1891	53	Has taken arsenic almost continuously for six years.
1892	54	Having left off her arsenic, she had a relapse and some large bullæ.
1893	55	I saw her at her home very ill with a severe relapse.
1894	56	Again cured by arsenic and advised to continue it.
1895	57	Still taking arsenic.
1896	58	Finally left off taking arsenic, being quite well.
1897	59	Quite well.
1898	60	Quite well.
1899	61	Quite well.

It had begun during lactation and after "a shock." She was stout but pale, nervous and depressed. She had taken arsenic with much benefit before I saw her. In the first instance she had been so covered with vesications and sores that she could neither sit nor lie. Arsenic invariably arrested the eruption, but she thought that it made her feel sick and ill, and she often left it off when her eruption was better.

Her expression in 1888, when she had taken small doses of arsenic for five years, was, "I did not think that I should live if I left it off." At times, however, she would become weak and of a leaden hue. Her dose was two minims of Fowler's solution, three of Pearson's, with ten of tincture of nux vomica and a little cascara to keep the bowels open. When she left it off she at once felt weak and languid.

Fatal Dermatitis in an Infant attended by Bullæ and general Epidermatolysis.

In October, 1895, I read in a newspaper the report of an inquest which was headed, "Doctors Baffled by a Skin Disease," and which, Dr. Clements Bawden being the witness, concluded as follows:—

"It might have been gangrene of the skin. He could not say if the exfoliation was due to natural or accidental causes. The Coroner: Was it poison? I think not.—Was it the violet powder? I don't think so.—The Coroner: Years ago it was discovered that the violet powder was not pure rice, but contained arsenic. Do you think it is due to absorption of anything like arsenic? No, I do not think it is arsenic or other mineral poison. Continuing, the doctor said that if it were a skin disease it was of a kind unknown—he had never seen it or heard it described. Death was due to syncope from shock from exfoliation of the skin, but he could not say the cause.—Dr. Ensor said he had never seen or heard of such a case.—The Coroner said it was an interesting matter, and if the inquiry closed science would know nothing of it. If it was adjourned, however, a specialist might be able to say the exact origin of it.—The jury did not wish to adjourn, but returned a verdict of 'Death from shock following exfoliation of the skin,' and after hearing the medical evidence, considered 'it was a case of skin disease,' although they could not say the origin."

I was tempted to communicate with Dr. Bawden, which done, he most courteously supplied me with full particulars.

DAY.	DATE.	DETAILS.
Saturday	Oct. 5	Born ; healthy. "Inward convulsions." Pot. Bromide, gr. i.
Sunday	6	Doing well.
Monday	7	" } The small doses of bromide were continued.
Tuesday	8	
Wednesday	9	Cord fell. Two small blebs on the neck.
Thursday	10	Iodoform ointment ordered.
Friday	11	
Saturday	12	The blisters had left raw surfaces as large as florins.
Sunday	13	Up to this date no anxiety felt. Attendance ceased.
Monday	14	Not seen. Vesication spreading.
Tuesday	15	Not seen.
Wednesday	16	The infant brought to surgery. Temperature normal. An extensive sore.
Thursday	17	"Looked as if it had been scalded."
Friday	18	Dr. Bawden visited the infant. Epidermis everywhere loose.
Saturday	19	Died in early morning. <i>Autopsy.</i> —Epidermis loose over whole surface. Excoriation at angle of left eye.

The following narrative of the case was kindly written out for me by Dr. Bawden :—

"An epitome of the clinical history of the case, notes of which I took whilst attending the patient.

"Saturday, October 5th.—Attended Mrs. P—— in her confinement. The child was a fine healthy girl, very well nourished. About three hours later there was bleeding from the cord, which latter I religated. Child seemed no worse for the loss of a little blood. Nurse said child had had 'inward convulsions.' Its facial muscles twitched, and it rolled its eyes up. I prescribed a dose containing a single grain of bromide of potassium.

"October 9th.—Two small blebs, each about the size of a split pea, had appeared on the neck. These I thought were produced by the starched trill around child's neck. I advised its removal, and prescribed ung. iodoformi P.B. and pad of wool, as convulsions still persisted. The bromide mixture was continued.

"*October 12th.*—The blisters had broken and left a raw surface of corium each about size of a florin. Up to this date I considered the condition as very simple and not dangerous. I thought that the blisters had been caused by mechanical irritation, and naturally the blisters broke and the epidermis exfoliated, leaving the exposed corium.

"*October 16th.*—Nurse brought the child to my surgery. The condition of the child looked much more serious. The epidermis had exfoliated over a large area. It seemed strange to me that the exfoliation of skin should continue now after the irritation had been removed and antiseptic treatment adopted. The temperature (in rectum) was normal.

"*October 18th.*—I was called to the child's home as the disease had developed considerably. I was surprised to find the peculiar (to me) condition of affairs. The corium was exposed, and red and irritable looking, over a large area on neck. Also on the vulva and nates the epidermis had separated, and corium was exposed. All over the chest and back the epidermis was loose, and could be slipped about over the subjacent corium, and the epidermis could be slipped off the hands and feet. An offensive smell as of putrefaction arose from the body. The umbilicus was healthy up to to-day."

Several diagnoses might be suggested. 1. Acute infantile pemphigus. 2. Erysipelas spreading from the excoriation on neck. 3. A dermatitis caused by the bromide. The absence of high temperatures and of congestion of skin seemed to distinguish the case from erysipelas. The prominent feature was loosening of the epidermis, so that it could be slipped about on the subjacent skin. The epidermis was loosened on the hands and feet, and "might have been slipped off." This epidermatolysis favoured the diagnosis of pemphigus. The vulva and nates were excoriated. The evidence of the child's father at the inquest was that it looked as if it had been scalded, but Dr. Bawden assured me that there was little or no redness.

NOTES ON SYMPTOMS.

(Continued from page 27.)

No. LVI.—*On the value of Lupus Erythematosus as a symptom of Constitutional Predisposition.*

As an adjunct to the case narrated at page 36, in which a very peculiar eruption, possibly of specific origin, finally resembled granuloma fungoides, I may give a few particulars as to a skin disease from which the patient's sister suffered. It is of great importance, in endeavouring to find the fundamental explanation of rare forms of disease, to trace out those which may have occurred in near relatives. In this instance the sister of our patient began at 17 years of age to suffer from lupus erythematosus on the scalp. She is now 38 years of age, and has four scars of considerable size left by the lupus along the vertex of the scalp. These scars are red and somewhat thickened, as those of lupus erythematosus so frequently are. The patient, now a widow, has two delicate children, but there is not the slightest reason to suspect specific disease.

If we may estimate the value of lupus erythematosus as a symptom, I should incline to say that it implies the presence and activity of the tubercle bacillus in some form, and, further, that it makes it exceedingly probable that this parasite has been present in the tissues for a long time prior to its manifestations. The general facts as regards the malady, its symmetrical developments, &c., make it exceedingly probable that it is constitutional and not local in its origin. Scarcely ever do we receive the history of any local injury having preceded its outbreak, whereas sunburns, chilblains, &c., are not unfrequently alleged. A strong history of tuberculosis in near relatives and in its most

definite forms is very frequently encountered. The facts as regards lupus vulgaris, although perhaps in the main similar, differ in that it is more frequently ascribed to some slight injury, and more commonly remains almost exclusively local. Accidental infection may with far more plausibility be suspected in it than in its congener erythematosus.

Thus, then, I think we may safely arrive at the conclusion that lupus erythematosus occurring in one member of a family implies proclivity to scrofulous, *i.e.* tuberculous, affections in the stock.

No. LVII.—*The Spontaneous Occurrence (local) of Sensations resembling those of an Electric Shock.*

The patient whose case is described at page 20 in my last number has experienced a recurrence of his curious symptom. The symptom consists in the repeated recurrence during six hours of shoots of pain in the outer part of the right foot in the area of distribution of the lesser peroneal nerve. During the months that have elapsed since the former attack he has been quite free. On the last occasion the attacks began in bed in the early morning, and one of them was possibly the cause of waking. They continued to recur one every half-hour or oftener till about eleven in the forenoon, and then ceased, not leaving any tenderness. The shoots of pain were like that of an electric discharge, and always passed down from the outer malleolus to the base of the little toe in several distinct lines. The shock itself was over in a second, but a smarting in the part with transitory tenderness lasted for five minutes or more. The pain of the shock was severe, and would have been intolerable had it lasted. Repeatedly it occurred when the foot was quite at rest, but several times it seemed to have been caused by movement. On one occasion there occurred a distinct but not severe shoot of pain up the course of the great sciatic in the back of the thigh. It was quite possible that the attack was in connection with some temporary gouty condition, but there was no conclusive evidence on this point. No other cause could be assigned, for its subject was in good health.

It is perhaps worthy of remark that three days after the attack, thinking about the symptom brought on distinct tenderness in the region which had been affected. No kind of movement could, however, induce a shock or any sensation approaching one.

No. LVIII.—*On “Superficial Neuralgia” and its possible alliance with Herpes.*

A lady who inherits gout, and has also in slight form suffered from it, replied in answer to my inquiry as to neuralgia, “I am liable to superficial neuralgia.” “What do you mean by that?” I asked. “I mean that I am liable to have one half of my scalp become tender so that I cannot brush my hair without causing pricking pain. It lasts a few days and then goes away completely.” I suspect that many persons are liable to this kind of pain, and that not a few of my middle-aged readers may have experienced it in their own persons. It is a sort of pain very similar, I think, to that which precedes an outbreak of herpes, but no herpes follows it. I have often thought that it must be allied to herpes, and should perhaps be reckoned as one of its abortive forms. It is always strictly onesided, and its favourite site is the scalp, exempting all other parts of the head and face. It is not attended by much, if any, sense of pain, independently of pressure, but the slightest touch suffices to elicit a crop of tingling pricks followed by a burning sensation. The liability always disappears after a few days, and the recurrences usually have intervals of a few months, or it may be years.

No. LIX.—*Recurring Attacks of Optic Neuritis.—Differential Diagnosis as to Gout or Syphilis.*

It is often, in cases in which those who are gouty have also suffered from syphilis, difficult to disentangle the resultant phenomena. This is more especially the case when the eye is the organ concerned. In the following case,

I believe that symptoms which were in the first instance assumed to be syphilitic were really caused by gout. Their recurrence after long periods of immunity, the time of year at which they occurred, and the entire absence of concomitant symptoms of syphilis all seem to point to that conclusion.

When on October 19, 1894, Mr. W—— was first brought to me, he was complaining of a “cloud-disc” before his left eye. He had already been for a month under an ophthalmic surgeon who had used the ophthalmoscope, inquired as to syphilis, and prescribed mercury. The history was that he had suffered from syphilis seventeen years before, and had then had a long mercurial treatment. Two years after this he had had some affection of his left eye (the one which now suffered), and had again taken mercury. Since then he had enjoyed excellent health, but he had on one occasion had swelling and redness of one great toe, which prevented him putting his boot on for a few days and then passed off. He was of gouty family. His present eye affection had come on suddenly, and the symptom of which he made most complaint was “a round blot or disc of a light purple tint in the line of sight” which prevented his seeing clearly. With the ophthalmoscope I recognised “optic neuritis,” but the appearances consisted only of a slight haziness and swelling of the retina and disc at its margins. He continued the mercury, and on November 2nd, after having been slightly salivated, he could see as well with one eye as the other, and the subjective symptoms had quite disappeared. As the margins of the disc were still hazy I advised continuance of treatment, and this was done in small doses till May 8th. During the latter part of this period he could, however, see perfectly, and was in all respects quite well. In March of 1897 (two years later) he came to me again with ciliary congestion and slight iritis in the other eye. He remained in town (in a Home) for two weeks, and took iodides and mercury. The eye got quite well. In March of 1899 he was for a third time under care, and on this occasion it was for a repetition of exactly the same symptoms which he had had in '94, “a cloudy disc of purplish tint before the left

eye." It obscured his vision, but did not wholly prevent his reading good-sized type. The attack had lasted a month, and he had already been treated with mercury to salivation. On ophthalmoscopic examination I found but little. The vessels on the disc were clear, but the edges of the disc both above and below were slightly hazy. The pupil had dilated well with atropine. Mr. W—— was in splendid health, and he had not for years experienced any definite symptoms of either gout or syphilis. He told me, however, that during the month preceding the attack in his eye he had been hunting and drinking beer, and that his urine had at times been very thick. He was accustomed to live well, but temperately, and his usual drink was cider.

No. LX.—*On Blood-Stained Semen and Hæmorrhage during Intercourse.*

Considering the state of vascular turgescence which attends the sexual orgasm it may be a matter of reasonable surprise that hæmorrhage so rarely occurs. Now and then such cases do occur, and with sufficient urgency to induce their subject to seek advice. I have seen a few both in women and men. I remember a woman past middle life, and in whom probably the vessels were not sound, being admitted at midnight into the London Hospital with an enormous blood swelling of the labium majus on one side of the pubic region and lower part of abdomen. The swelling was still increasing when she came in, and it was necessary to apply ice-bladders to arrest it. She acknowledged that it had commenced during the sexual act. In men the complaint has usually been of bleeding, only very small in quantity, following the act. I do not remember a single one in which treatment was needed for its arrest.

A symptom, no doubt due to bleeding at some part of the sexual tract, is that of rust-coloured semen. This condition is usually detected only by observing stains on the night linen. It is sometimes attended by what looks like pure blood. A case of this kind has recently been under my observation.

Mr. B. W——, a married man of forty, was sent to me because he was very unhappy from having noticed his night-shirt stained brown or red. This was observed alike after intercourse and after spontaneous emissions. Mr. W—— had up to the time of marriage been much troubled with the latter, and, even since, a week or two's abstinence was almost sure to cause them. The semen, he said, was almost always brown, but at times it would be as red as blood. He had never, however, experienced any flow of blood; it never appeared otherwise than as staining the semen. Occasionally, but not often, for a few weeks the semen would be almost or quite free from colour. Mr. W—— was in good health, and the only concomitant symptom was a liability to slight tenderness in the left testis. I examined the organs carefully, and could discover nothing abnormal either in the testes or vesiculæ seminales. Some facts in my patient's history might not improbably have some connection with his symptoms. He knew of no gout in his family, but one of his sisters and himself had both been very prone to epistaxis in early life. The blood-staining of the semen had been observed for four years, and for several years before it began he had been liable to attacks of a purpuric eruption on his legs. The spots, which he described as very small, would come out in successive crops for several weeks together and then wholly disappear. They usually left stains, but of the latter no traces now remained. It was now three years at least since his last attack.

My diagnosis in this case was that there probably existed somewhere in the vesiculæ a little nævoid or papillary growth, which occasionally bled. The duration of the symptom made it clear that there was no malignant disease. I saw the patient for a first time on February 8, 1898, and a second on January 25, 1899, and he had in the interval improved rather than otherwise in health, whilst the state of the semen remained as before. It should be added that he had recently noticed on his linen little "gelatinous knobs" of a brown colour, but not, he said, like blood-clot. Of these he promised to send me some for microscopic examination.

No. LXI.—*Gouty Neuralgia of the Tongue.*

An instructive illustration of gouty neuralgia of the tongue is afforded by the case of Mr. D——, of St. Albans. This gentleman, a ruddy complexioned man of 56, has suffered for the last seven years from almost continuous neuralgia in the left side of his tongue. The pain, although however almost constant in the daytime, never interferes with his sleep. It always leaves him when he lies down in bed, and does not return till he rises in the morning. In bed he can talk freely and never experiences the slightest pain. Mr. D—— avers, however, that he has never been a whole day without it of late years, and usually it is present all day. It is not made worse by movement, and he can eat in comfort. When it is at its worst there is some tenderness, otherwise there is none. The site of the pain is, as usual in these cases, on the left side of the tongue, near its base. There is nothing whatever to be seen; but at one time the whole tongue was somewhat swollen, possibly in connection with mercury, which had been given. Caustics, nitric acid and others, have repeatedly been applied to the part, but with only temporary benefit.

When Mr. D—— was first brought to me he had been for long treated for syphilis, but I could find no evidence of it. He was a married man with four healthy children. He had always, with this drawback, enjoyed good health. He had never himself suffered from gout, but two paternal uncles had done so, and one of his sisters. He had lived moderately, but had taken beer regularly.

When I first saw Mr. D—— on January 7, 1895, I prescribed aconite and colchicum, and for some months his pain was much reduced. He did not, however, continue the medicine long, and I did not see him again for four years. In February, 1899, an aggravation of the pain induced him to come to me again, and he then gave me the remarkable statement which I have just recorded:—that he had never been for an entire day wholly free. He did not describe the pain as very severe, but said that it was continuous, and

when at its worst he compared it to a mild toothache. It never passed to any other part, with the exception, perhaps, of the back of the neck at times, and now and then slightly to the opposite side of the tongue.

I have seen many examples of this form of neuralgia of the tongue, but although all are intractable, none, I think, have been so persistent as the above. It is a remarkable fact that it is almost always the left side of the tongue which is affected, and that all the patients refer the pain to the same part. Quinine, aconite, and colchicum, with a careful regimen, are the best remedies, but they are often not quickly successful and seldom prevent relapses.

PARANGI, YAWS, AND SYPHILIS.

I HAVE recently repeatedly expressed the opinion that the disease known as Yaws is definitely Syphilis, and that there are no real differences to be observed. The kind of evidence which is obtainable on this question is in part traditional, and not much better than hearsay. The disease has, however, received the attention of some able observers. Their statements as to facts, however, are by no means unanimous, and not unfrequently contradictory. Under these conditions any one who wishes to arrive at correct inferences is obliged to strike, as it were, a balance, and to form his own conclusions as to what is probably true. It is needless to state that observations conducted amongst aboriginal populations, and often under much pressure of occupation, cannot be expected to be free from errors. The observers who have written on Yaws have but rarely enjoyed the advantages which a more or less public criticism affords in England.

The following statements *pro* and *con* on this important question were compiled for me ten years ago, at a time when my opinion on this question was less definite than it is at present. I offer them to my readers just as they were then written, in order that they may be able to judge for themselves as to the kind of data which are obtainable from the literature of the subject.

It is only necessary to add that it is universally acknowledged that the affections known in Ceylon and some parts of India as "Parangi" are identical with those which in South Africa and the West Indies are known as "Yaws." The statements here produced do not include any of the more recent pronouncements as regards the nature of Yaws; and I have thought it better to omit the names of the authorities quoted, in the desire, as far as possible, to rid the discussion

of the personal element. They are all from those who have enjoyed abundant opportunities of personal observation.

In favour of Parangi being Syphilis.

Dr. D. believes it to be "a form of Syphilis degenerating into Leprosy."

Dr. R. thinks many of the cases to be Syphilitic.

Tradition ascribes its introduction to the Portuguese in the fifteenth century, and it is sometimes called Spanish Pox. The word Parangi means "the Portuguese" or "foreign disease."

Dr. T. says "it is nearly always preceded by an ulcer," generally situated above some bony prominence.

It is hereditary (Dr. D.); often acquired by cohabitation, or by children playing with or taking food with the diseased. Dr. R. D. says the people of Ceylon are most immoral. "Suckling babes" have been seen affected.

A clay-coloured complexion, a peculiar cachexy, muscular pains, and loss of appetite accompany the eruption. Pains in the bones are also spoken of.

The eruption is polymorphous—generally squamous or tubercular, but in debilitated subjects vesicular or pustular. Psoriasis is frequent, and palmar and plantar forms of it often met with.

"Dark stains are invariably seen" after the ulcers have healed.—Dr. R.

It seems to be not commonly fatal; though there are strange contradictions on this point—one observer saying that "it decimates the people," another that "the duration of life is not much affected by it."

Nodes on the bones of the head, forearms, and legs are frequent; the tibiæ often arch forward; the large joints are often swollen and painful.

"Gummata" are found in the subcutaneous tissue.

The periods given for its stages are:—1. Incubation: two weeks to two months. 2. Premonitory fever: dull pains in bones and joints, malaise, two to eight days. 3. Eruption stage, which ends in resolution, or a period of sequelæ.

Many writers agree as to Parangi being not auto-inoculable.

Against Parangi being Syphilis.

Several hold that many of the cases are true Syphilis, and can be more or less cured by mercury and iodides; whilst other cases yet remain of a different and distinct disease.

Dr. R. confidently asserts that Parangi is not Syphilis, and is in no way related to that disease.

It is ascribed to bad living, &c.; but there is little or no positive evidence; and the causes given are most various—bad water, diseased maize, “kurakhan,” malaria, bad ventilation, &c. That it is not due in all cases to any of these causes is shown by Dr. Anthonisz’s report that he had seen it in the children of healthy Europeans from playing with native children. Marriages of consanguinity and wet weather are said to increase it.

Dr. R. says the geographical distribution of the disease is that of deficient water supply and artificial storage of water.

It is said to often originate from wounds or scratches.

It is “rarely seen in the large towns,” whilst in some villages nearly every inhabitant has it once or oftener in his life.

Dr. R. says that the cases of Parangi in children its subjects do not bear evidence of inherited syphilis—either in their teeth, or eyes, or epiphyses. He admits the benefit of mercury in both, but does not attach much importance to it.

Mr. G., whilst admitting that the Parangi eruption is “just like syphilitic rupia,” that the disease “is most amenable to mercurial treatment,” and that it has been transmitted sometimes through sexual intercourse,” yet says that it is not hereditary, and is not syphilis.

Both he and Dr. R. believe miscarriages to be rare amongst women severely affected with the disease.

Whilst Mr. M. says Parangi is not a disease of mal-nutrition—both poor and rich being alike attacked, others assert that bad food and water are its chief causes.

HIRSCH'S ARTICLE ON YAWS.

Hirsch's article on Yaws * is full of valuable facts, but his arguments and inferences are some of them very curious. He contends that it is not syphilis. After stating that the typical characteristics of the eruption perfectly distinguish Yaws from syphilitic diseases of the skin, he adds, "but more especially the fact that Yaws has none of the properties of a constitutional disease, that it has markedly the character of a local malady, that it always ends in complete recovery without medical treatment, and that the use of mercury in Yaws has been found to be absolutely injurious." This statement reminds one of the celebrated description of a crab as "a red fish which walks backwards," every part of it being untrue. Yaws is unquestionably amenable to small doses of mercury; it is not more easily recoverable without treatment than is syphilis; it is most certainly, like syphilis, a constitutional disease preceded by an infecting sore. When Hirsch further adds on the authority of Charlouis and others that both diseases have several times been found together in the same person, each running its course with "the phenomena peculiar to it," we are obliged to ask what are the "peculiar phenomena"? If in a case of Yaws the mucous membranes are affected, is it fair to say that two diseases are present, and not rather that in some cases sore throat may occur as a part of Yaws? Absence of sore throat and the framboesial character of the eruption are almost the only features in which Yaws is alleged to differ from syphilis. But this may be an instance of observation in a circle, for if there were no sore throat and the eruption were not of the framboesial type, the case would be declared to be syphilis and not Yaws.

*Cases of Syphilis after Yaws, and Second Infections
of Syphilis.*

Almost the only statement in favour of the non-identity of syphilis and yaws which it is the least difficult to confute,

* See "Handbook of Historical and Geographical Pathology," New Sydenham Society's translation, vol. i., p. 101.

is the record by Dr. Charlouis that he induced syphilis by inoculation in a patient recently recovered from yaws. It is an isolated case, and it is, besides, open to the reply that second infections of syphilis are in some instances possible after very short periods.

A noteworthy instance of an early second infection of this kind occurred in the case of a Spanish gentleman who consulted me in March, 1899. He was forty-five years of age when he contracted his first chancre. It was recognised just as his secondary eruption was coming out, and he was treated at first by pills, and subsequently by inunction with sulphur baths at Vizella, the Aix la Chapelle of Portugal. To these baths he went twice, and had the inunction carried out vigorously, especially so on the second occasion. He had had a relapse of eruption in the interval between his two visits to Vizella, but on each occasion the inunction treatment had promptly cleared away all symptoms. On leaving, on the second occasion, he was enjoined not to take any mercury internally, but to come again in a year. This was early in July. He remained apparently well until the end of August, when, as he believed, he contracted a fresh sore. It followed suspicious intercourse in due course, but as it was in the site of the former sore (the mucous surface of the reflected prepuce), his surgeon diagnosed "a recurred induration." It was, however, followed by a more severe development of eruption than he had ever before experienced. He became covered with serpiginous patches, of which plentiful stains and scars remained when he came to me six months later. One of these was of decidedly lupoid character. On this second occasion he was treated chiefly by iodides, but probably with some mercury.

Whilst it may be admitted that the evidence would in the above case have been more nearly conclusive as to a new infection if the second chancre had been on a different site from that of the first, there is yet considerable probability in the patient's own conviction that he had received a fresh contagion. The fact that it was followed by a very definite outbreak of eruption gives support to that view. I have known two or three others which may be placed by its

side as examples of fresh sores contracted within twelve months of the first, and in which the second was on a different site from that of the first. They are paralleled by what we know as regards some other specific fevers in which second infections have followed very quickly after the first. Some persons seem to acquire only a very brief immunity either as regards vaccination or smallpox itself.

*On the Local Substitution of one Malady for another
and its Explanation.*

A not uninteresting topic has been opened for consideration in connection with the identity between syphilis and yaws. It concerns the substitution of the one disease for the other in different localities, and the question as to whether there is any law in this matter. My attention was in the first instance drawn to it when told by my friend, Dr. Daniells, that in the Fijis yaws alone is met with, and not long afterwards by another friend, Sir William Kinsey, who told me that in Ceylon the one disease prevails in country districts and the other in towns. Being desirous to discover whether this apparent law of substitution prevailed in other places, I have searched in Hirsch's Handbook and in other sources for information as to the relative prevalence of the two maladies. The results of my search are briefly epitomised in the appended table. It can scarcely be necessary to explain that the statements here quoted must be regarded as only approximately correct. They depend upon the observations of individuals, and have probably not been in many cases subjected to general scrutiny. They are nevertheless of considerable value for my purpose. It will be seen that there is apparently some law of substitution. In many instances the district in which the one disease is said to be common is precisely that in which the other is said to be rare. In some, however, the two are common together. The explanation of this apparent substitution is, I think, tolerably easy. If we were told that "osteo-arthritis" was common in Lincolnshire and "rheumatic gout" unknown, whilst it was the reverse in Yorkshire, or that "varioid" substituted in Bath the

“varicella” which was common in Bristol, we should know what to believe.

COUNTRY.	SYPHILIS.	YAWS.
Africa within the tropics —Senegambia, Angola, Soudan, Timbuctoo, Bonom	Immunity asserted by some. Living- stone asserted that “Syphilis does not hold with pure Ethiopian blood.”	Common.
Africa North and North- East—Nile Valley, Abyssinia, &c.	Common but mild.	Rare.
Madagascar, Comoros, Mozambique	Remarkable immunity	Fairly frequent.
Ceylon	Common in towns, rare in country places.	Common in country places, rare in towns.
New Caledonia, Fiji, and Samoa	None.	Common.
Mainland of Hindostan and Further India	Abundant and severe.	Very rare.
China	Common.	
West Indies	Rare and mild.	Common.
Guiana and Brazil	Common.	Common.
Central America	Common and severe.	Rare.
Argentine Republic	Common.	Unknown.
Malay Archipelago	Common and severe.	Common.
Europe	Common.	Met with only as a form of syphilis.
British Isles	Common.	Met with only as a form of syphilis.

It is not to be suggested that difference in local nomenclature is all that we ought to mention as explanatory of this apparent substitution of one disease for the other. This may be the chief one, but there are probably others which are contributory. Of these, race and climate are probably the principal ones. The framboesial type of syphilis may occur in any country and in any race, but it is rare in some and common in others. It would appear to be the rule, with but few exceptions, in the pure African race and amongst the Fiji islanders. In Europe and in white races generally it is so exceptional that it is rarely diagnosed, but gets some other name, “Morula,” “button scurvy,” and the like.

A CLINICAL STUDY OF DISEASES OF THE NAILS.

I HAVE from time to time in the pages of my ARCHIVES devoted considerable attention to Diseases of the Nails. The topic is one of wider interest than may at first sight appear to be the case. It is not only that affections of these appendages are very disfiguring and cause much annoyance to those who suffer from them, but that they are often of much value as symptoms of other maladies or indications of the state of the general health. In reference to these wider subjects they are deserving of more attention than they have yet received. I purpose now to deal with the subject in a somewhat systematic manner in the hope of being able to obtain from its detailed consideration some valuable hints not only as to the treatment of nail diseases, but as to their value and meaning as symptoms.

In order to avoid repetition and to facilitate reference, I will in the first place briefly recapitulate what I have previously written on the subject.

(a) *Psoriasis of nails.*

The case of Mr. G——, —one of the first in which I carefully studied the form of nail disease which attends common and typical psoriasis of the body—is recorded at page 151 of my Clinical Lectures on Rare Diseases of the Skin. Mr. G—— was the object of severe psoriasis, and was under my observation for several years. His nails used to loose their attachment to the nail-bed at their free borders and edges. The loosening was always preceded by a patch of discoloration, visible through the nail. Both the psoriasis of the trunk and the affection of the nails were controlled, and often for a time quite cured, by the use of arsenic. The toe

nails as well as those of the fingers suffered. The nails usually remained quite smooth on their surfaces.

In the same lecture are several other examples of "Psoriasis of the nails." In one remarkable case the loosening of the nail would sometimes occur, not at its margin, but at its middle, and would lead to breaking up of the nail structure. Sometimes one finger and sometimes another would suffer, and in some instances nails which had been affected had been well reproduced and had remained sound. There was some tendency to palmar psoriasis, but otherwise the patient was in good health. Although in some of the nails the loosening began at a little distance from the free edge, the final condition was in all respects that usual in psoriasis.

(b) *Syphilitic disease of nails.*

An example of the mixed form of specific nail disease is recorded on page 370 of Vol. VIII. of ARCHIVES. A young man, aged 24, had during the secondary period, and coincidentally with sore throat and psoriasis palmaris, inflammation of almost all his nails, both of the toes and fingers. In most instances almost the whole nail was involved, the entire matrix being congested, and the nail thrown into ridges. Some looked as if they had been pinched up laterally, and others showed well-marked surface-erosion, usually beginning at the lunula, whilst others were loosened at their edges as in psoriasis. The specific psoriasis of the palms and soles was severe and well characterised. It was nearly eighteen months since the primary symptoms.

(c) *Opacities in the nail substance.*

The white specks in nails which are familiar to everybody result from opacity of the nail structure. Some have thought that they were due to the presence of air in the nail, but I do not know of any evidence which is conclusive on this point. In most cases undoubtedly they follow slight injuries. The reader will find at page 372 of Vol. VIII. of my ARCHIVES an interesting note by Dr. William Sykes, of Gosport, recording his personal experience, and showing

that they may be caused experimentally by inflicting damage on the surface of the nail near to its root. Thus, roughly pushing back or detaching the border of the nail-fold may produce them. In rare instances white bands crossing the whole width of the nail may be observed, and these are always the result, not of local injury, but of vascular disturbance in connection with some febrile illness. They represent a sort of minor form of the disturbance of nutrition, which in typhus fever and many other maladies results in transverse furrows.

(d) *Nail-disease in association with skin-disease.*

The case of Miss M—— is recorded as No. 107, page 374 of Vol. IX. She inherited a tendency to eczema-psoriasis, and possibly to xerodermia. Miss M—— was aged 16, and in excellent health, but she was much annoyed by the condition of her nails. They were undermined and liable to much accumulation of dry dust between the nail and its bed. The nails of the thumb were the most affected, and the little and ring fingers almost wholly exempt. She had some dry eczema-psoriasis patches in the fold between the thumb and forefinger and on the elbows and knees. The rest of her skin was quite healthy. One of her brothers had suffered most severely from eczema and asthma, and was obliged to live at the seaside. In addition to the loosening from their beds, the nails were much pin-pricked.

(e) *Chronic Onychitis with thickening.*

My earliest description of "a peculiar form of chronic Onychitis, with thickening of the nail substance, but without skin disease," occurs at page 156 of my Clinical Lectures on Rare Diseases of the Skin. I there described a chronic multiple and usually symmetrical form of nail disease, characterised by thickening of the nail itself, with great roughening of its surface. My then experience was that it occurred chiefly in young persons, and that I had never seen it in connection with ill-health or diseases of the skin or any other form of diathesis. Although not associated with psoriasis, I found arsenic in full doses to be the only

remedy which cured it. I mentioned that the nail substance became extremely thick, but was at the same time somewhat softened, and might contain minute deposits of pus, and would bleed when cut. It was also recorded respecting at least one case that the symmetry was very accurate, that the thumbs and great toes suffered the most, and that the little and ring fingers of both hands escaped.

This condition had been well described by the late Sir Benjamin Richardson in his *Asclepiad*. In one of his cases, the subject of a good chromo-lithograph, the patient was the subject also of common psoriasis. He bears strong testimony to the efficacy of arsenic in the disease. (See *Asclepiad*, vol. i., 1862, page 30.)

(f) *Liability of the radial digits to suffer first.*

The case of Master B——, recorded at page 279 of Vol. VIII., affords an interesting illustration of the liability of the radial digits to suffer first. In him the thumb and forefinger of the two hands were the only digits which had suffered. The nails of all his other fingers and of all his toes were quite sound. He was in excellent health, and his family history was quite negative as regards anything bearing on his nail disease. The nails on the digits mentioned had been almost wholly destroyed, and were represented only by fibrous bands, which were thickest over the lunula, and became very thin towards the extremity. I was told that the affection had commenced about two years ago, and that some little holes in the affected nails near to their roots had been the condition which first attracted attention. After this the nails thinned and broke up.

(g) *Congenital absence of nails.*

I have briefly mentioned at page 253, Vol. II., the cases of a brother and sister named T——, who were born without hair and without nails. They were aged 8 and 7 years respectively when under my observation in September, 1875. At that time their nails had grown well, but the development of scalp-hair was still very defective. The absence of nails at birth had been noted both on the fingers and toes.

(h) *The nails in members of gouty families.*

At page 250 of Vol. IV. will be found a note on the state of the teeth and nails in gouty persons. As regards the nails, I have there stated my belief that those of the better classes in England who are of gouty families very usually have good sound nails, "thick, solid, transparent, and brightly polished, and that such nails, as a rule, imply general soundness of tissues."

(i) *Derangement of circulation.*

Amongst the conditions due to physiological derangement of circulation, as exhibited by the nails, we have the appearance of a dusky, purplish, transverse band under the nail, close to its free edge. Even in persons in good health and whose circulation is vigorous this part of the nail-bed is usually more deeply congested than the rest. By pressure of the finger-tip on some hard substance the blood can be easily expelled and made to recede upwards, leaving this part white. In various conditions of enfeebled circulation the venous congestion of the part referred to may be much increased, and may become very conspicuous. I have noticed one such case in Vol. V. at page 276.

(j) *Psoriasis of nail-bed after syphilis.*

A good example of the loosening of the nail from its bed is mentioned at page 86 of Vol. VII. The case was that of a gentleman who attended at one of my demonstrations, to show his nails, on November 12, 1895. All his nails had suffered, and all were exactly alike; the distal third on every finger being detached so that a probe could pass under it. He had suffered from specific disease two years before, but was apparently in good health.

(k) *Patches of discoloration seen under the nail in psoriasis of nail-bed.*

In a case given at page 72, Vol. IX., I have mentioned the facts respecting the early stage of psoriasis of the nail-bed. The nails of Mr. T—— were becoming discoloured and loose from their bed. The loosening began at their sides, as well

as at their free edges, but had not as yet proceeded very far. Under one nail there was an abruptly margined patch of discoloration as big as a threepenny piece. It was easily seen through the transparent nail, but did not quite touch the free border. Some of his other nails showed brownish discoloration beneath them, running in ill-margined streaks. The changes in the nails had been noticed only for a few months, but for four years past the patient had had large patches of psoriasis on his scalp.

It may be convenient in the first place to recapitulate a few anatomical facts.

The nails are epidermic structures, and consist of closely-packed epidermal cells, which have assumed the condition of transparent horn. Excepting in states of disease, they are not fibrous.

They are placed upon a bed of vascular papillæ, which are arranged lengthwise in rows, and from which they receive on their under surfaces constant increments of thickness.

The parts which have received names are the body, the root, the free edge, the sides, the lunula, the matrix or bed, and the groove. Where the skin overlaps the edges of the nail it constitutes the nail-folds.

The skin is continuous with the nail at its root on both upper and under surfaces, but at its free edge on the under surface only, as the nail, now much thickened, is projected forwards unattached.

The part which is named the lunula is a crescentic portion which arches forward from the root, and is of an opaque white structure. It seldom extends quite to the lateral borders of the nail.

The lunula is largest in the nail of the thumb, and decreases with each digit to the fifth. Its size varies in different individuals and in different races. But few Englishmen have any definite lunula to the nail of the little finger, and many have none to that of the ring finger. It is usually conspicuous and large in the Semitic races, and almost absent in the Hindoos.

The opacity of the lunula depends in part upon diminished vascularity in the matrix beneath it, and in part upon opacity of the nail structure. The explanation of the abruptness of its margin is not easily given. Beneath the lunula the papillæ are not arranged in rows, but irregularly.

A nail is in constant process of growth, increasing both in thickness and length. The lunula and root supply the cells by which the nail increases in length and is pushed forward, the papillæ of the matrix those by which it increases in thickness.

Exclusive of pathological changes, considerable differences may be observed in the nails of different persons.

The nails may be strong, thick, smooth, and well polished, or they may be thin, striated, and fluted and wanting in lustre. Variations in these conditions are no doubt matters of inheritance, and may indicate differences in the endowments of the tissues generally, but especially of the epidermis and its other appendages.

Nails may differ in their form, and may be broad or narrow, flat or convex, long or short.

Nails may be brittle or strong. If the former, they are prone to break up at their free edges; and if the latter, they project forwards with smooth rounded edges.

In some persons a tendency of the nail-fold to grow forwards and to unite with the nail surface and conceal it is a source of annoyance.

In many the very slightest injury done to the nail near its root causes a local opacity, and the nail as it grows forms and exhibits white spots in consequence—"white lies."

Pathological Processes.

Amongst the special pathological processes which may be observed in nails are the following:—

Suppurative inflammation of the nail groove, either local or general, and often extending more or less to the matrix. If this involves all or many of the nails it constitutes a sort of sycosis inguium, if it involves single nails we have the various forms of onychia.

Loosening of the nail from its bed. This usually begins at its free edge, but may extend to its sides. It is usually attended by more or less accumulative epidermis under the nail, lifting it up, and also causing it to look opaque and dirty.

Erosion of the surface of the nail. This is always seen to begin at the nail root. A peculiar form of local erosion is common, in which little pits form, as if the nail had been pinched, and exactly resembling the specks in the leaf of a holly—"the pin-pricked nail."

Little vascular spots may form under the nail in its matrix, and be visible through it, and may gradually cause thinning and perforation.

The nail substance may become thickened and fibrous. This thickening is always attended by opacity of structure, and often by softening. The nail substance may become succulent, and even vascular, and may exude fluid or blood when cut.

In connection with an inflammatory process beginning at the lunula, the nail may form ridges which run longitudinally down its middle. If the nail be strong these ridges may be hard and elevated, but if weak the middle of the nail may become thin and broken. Until late stages the sides of the affected nails remain smooth, but in the end the whole nail is involved and may be destroyed.

Allied to this last condition is one in which the nail may be completely destroyed, and its bed become cuticular, and in which the nail-fold over the lunula is prolonged forwards over the bed as a fan-shaped, fleshy pterygium.

Nails may show transverse furrows. These are usually the results and the record of some illness attended by rigor or severe depression, which temporarily interfered with the nutrition of the nail. Such furrows become marked only in thick, strong nails.

In some cases the accumulation of epidermic scales under a loosened nail may unite with it and cause it to become thick and convex, like a claw. The most marked examples of this are congenital.

Nails are sometimes so thin, and their subjacent matrix

so poor, that the nail, instead of presenting a convex surface, is depressed into a slight hollow—"the spoon nail."

The nails may be attacked by the Cryptogam of Favus or by that of common ringworm, and in each instance the fungus may spread in the nail structure, and cause it to break up and become fibrous. It would appear that the fungus does not very easily gain access to the nail substance; for whilst ringworm of the scalp is very common, ringworm of the nails is very rare. Nor when one nail is affected does it readily spread to others, and not unfrequently, I believe, is it restricted for months, or even for years, to one or two nails. The conditions produced by the presence of the fungus may probably vary a good deal in relation, perhaps, with the previous endowments of its structure. In all cases the nail becomes opaque, fibrous, and thickened; but in some there may be a condition of soft swelling, attended by moist exudation. I am speaking chiefly of ringworm of the nails, for I have seen only three or four instances of favus, and in some of them it appeared that the nail-bed rather than the nail itself was the part affected. Sometimes a yellow favus crust may form under the nail, and lift it from its place. This condition is shown, I think, in a portrait which I was allowed to copy from one in the Leeds Museum. In a case which was under my own observation a quite different condition of things resulted, and the nails and the adjacent parts of the fingers were involved in the common inflammation, without the slightest naked-eye evidence of any favus crust. The nails were softened, broken, and destroyed. Excepting from the evidence afforded by contagion to others and the discovery of fungus by the microscope, no one would have suspected that the case was one of favus.

Transverse White Bands in Nails.

The first detailed description of Transverse White Bands was, I believe, given by my late colleague, Dr. Langdon Down. In the 21st volume of the Pathological Transactions he recorded the case of a gentleman who had suffered from severe attacks of prostration in connection possibly with overwork. Ulceration of the cornea, inter-

mittent action of the heart, and such debility that the slightest exertion overcame him were the principal symptoms. He had one attack in the middle of July, 1869, and about six weeks after it white bands were observed in the nails of his fingers and toes. They were transverse, extending the entire width of the nail, and as opaque as if painted with white lead.

The digits of the left limbs were more definitely marked than those of the right. In August of the same year another attack of nervous prostration occurred, and again, a few weeks later, other white bands in the nails were produced. The bands representing the two successive attacks were present at the same time, and it was six months before they were obliterated by the onward growth of the nails. Dr. Down does not state which nails were most definitely marked, nor whether there were any transverse furrows on any of them, nor is the age of the patient recorded. Although this is the first detailed record of white lines occurring in the nails as a record of temporary illness, yet it is possible that others had previously observed them. I find mentioned in a paper by Vogel on Affections of the Nails occurring after Typhus, &c., the mention of a "white anæmic stripe above the lunula in several or all the fingers." A case of my own, which I have next to relate, will place this white band of opacity in its proper position in relation to the transverse furrows which have attracted the attention of many observers. In order of severity the nails of the several digits, I believe, usually suffer less as we approach the little finger. This law seems to be general in all affections of the nails which occur in connection with derangements of general health, although it has its exceptions. As a rule, the thumb suffers most, the index finger next, and so on; whilst the little finger, and sometimes the ring, wholly or almost wholly escape. In the case which I have to record transverse furrows were very deep and conspicuous in the nails of the thumb and the index, less so in that of the middle finger, and absent in those of the ring and little one. In the nail of the little finger nothing whatever was visible, but in that of the ring finger a white band crossed the nail at

exactly the same level as the lowest furrow in the other nails. It seems clear, therefore, that this band of opacity represents a minimised disturbance of nutrition, less, that is, than what would have been competent to have produced a furrow.

In my case the condition was well marked in the nails of the right hand, but was less distinct in those of the left.

Erosion of Surface of Nail beginning from the Lunula.

A woman aged 73 was sent to me by Dr. Hingston Fox in November, 1878, for what was described as "a painless affection of the finger-nails of four months' standing." The old woman was in good general health and had no skin disease. Both thumbs were affected, and on the left hand the adjacent three fingers suffered also. The conditions

were precisely the same in all the affected nails. There was deep erosion of the nails on their upper surface, beginning at the root and presenting an abrupt limitary margin about a third upwards on the nail. Thus the anterior two-thirds of the nail were fairly sound and smooth. There was no inflammation, no thickening, and no pain.

Disease of the Nails symmetrically affecting the three Radial Digits and beginning at the Lunula.

Mr. Burgess made a very good sketch of Miss D——'s nails. Their affection consisted in a sharply elevated hard ridge which extended longitudinally from the middle of the lunula, and at about a third of the distance from the free

edge cracked into the arms of a Y. The skin overlying the lunula had been drawn forwards over a small area and was closely adherent to the surface of the nail. The thumb, index and middle fingers were those affected, the nails of the ring and little fingers being quite smooth. It was clearly the same affection as that shown in Mr. H——'s case (Plate 138). The disease evidently began at the lunula and extended forwards.

Miss D—— was a dark-complexioned Jewess, who had formerly suffered from lupus of the face and who was of tuberculous family. Her lupus had been quite cured and its scars were sound. She had herself been suspected of phthisis. I do not think that there was any reason to suspect syphilis, either inherited or achieved. She was about thirty-six years of age and had been under my observation for fifteen years.

On mixed forms of Skin Disease with affections of the Nails
—“*Eczema-psoriasis.*”

A not unimportant outcome of the detailed study of diseases of the nails is the confirmation which is afforded to the doctrine of mixed types of disease. Especially we seem to have repeated illustrations of the frequent impossibility of making a diagnosis between affections which are called psoriasis and some which are called eczema. That there are cases the true nature of which is best recognised by the use of the term “eczema-psoriasis,” I have long contended. The classification of the cases into two definite groups is, I would submit, quite impracticable. The mixture of the type forms shows itself in the same patient both on the skin and on the nails. The type-form of nail disease which occurs in patients who either are, have been, or will be the subjects of typical psoriasis, is a loosening of the nail from its bed, which begins at its free edge, or sides, or both.

The type form of nail disease in association with eczema is, on the other hand, an affection of the surface of the nail, which begins at its root and in connection with the skin-fold. In typical psoriasis the surface of the nail remains smooth, whilst the nail becomes loose. In typical eczema

the surface of the nail becomes rough, fibrous, pin-pricked, and broken, but the nail remains attached to its bed. In a great many cases, however, these two conditions occur together either in the same nail or in different nails of the same patient, and when this is observed there is almost always a mixed form of skin-disease.

I would claim as "eczema-psoriasis" of the skin, cases in which the eczema patches are abruptly margined, scaly, and quite dry, in which they more or less resist treatment or are very liable to recur after partial cure, but in which the eruption avoids the psoriasis positions. Very often some of the patches are quite indistinguishable from those of psoriasis, whilst others are like those of eczema. The scalp, the ears, and the hands are very frequently affected. If the family history be taken, we very often find that in these cases typical psoriasis and typical eczema have occurred in near relatives.

My conviction is that we are in the habit of separating psoriasis far too definitely from its congeners, and that we allow the very obvious peculiarities which characterise its definite forms to blind us to the fact that there are more deeply lying features of resemblance. These features point, I think, unmistakably to essential identity in some of the causes which are at work in the production of these maladies. Modern dermatology has taken the direction of attempts at separation, description from external features, and classification rather than the search after causes. Some of our forefathers were perhaps more philosophical than we are in these respects, and in the recognition of a dartrous diathesis by the Paris School they afforded us possibly a more truthful recognition of facts than is now at vogue amongst us.

The following fragments of Bibliography may perhaps be useful to some of my readers. I have not added recent papers. Many of these may be consulted in the "Extract Book," NAILS, now deposited in the Library of the Polyclinic in Chenies Street :—

† 1869. Wilks, *Lancet*, 1869, i. 5 and 66.

† 1870. Hilton Fagge, *Guy's Hospital Reports*, 3rd series, vol. xv., p. 551.*

* Hilton Fagge's paper contains two cases of diseased finger-ends and nails which may be compared with Dr. Ogle's cases in *Pathological Transactions*. Dr. Hilton

1846. M. Beau, "Archiv. Gén. de Médecine," 1846, séries iv., t. xi., p. 447 (referred to by Wilks and Fagge, and probably fully noticed by Wilson in his work).

Pathological Transactions:—

x. 108 (1859). Overgrowth in Cyanotic Fingers. Dr. J. W. Ogle.

xii. 241 (1861). Overgrowth of Nails. Mr. Partridge.

xiii. 259 (1862). Psoriasis in Syphilitic Persons. Mr. Hutchinson.

xiii. 260. Diseased Nails in Inherited Syphilis. Mr. Hutchinson (Plate).

xv. 65 (1864). Separation of Nails, with Ulceration of Finger-ends, in a case of Arrested Circulation in Arms and Legs. Dr. J. W. Ogle.

xvi. 268 (1865). Hypertrophy, &c., of one Finger-nail in connection with Neuralgia of same Finger and of Arm. Dr. J. W. Ogle.

* xxi. 409 (1870). Case of Transverse Markings after Illness. A very good case. Dr. Down.

Hillier, a "Handbook of Skin Diseases"; Richardson, "Clinical Essays," 'Asclepiad,' vol. i., p. 30, 1862.

Injuries to Nails and their Consequences.

There is a group of cases in which usually only one nail is affected, and in which some injury is usually suspected as having been the exciting cause. The history of injury is, however, not infrequently vague, and it is clear that but little damage could have been done. The peculiarity of these cases is that the chronic inflammation of the nail-bed persists, the nail being reproduced over and over again with great persistence, but being again broken up and shed in fragments. The evidences of inflammatory action may vary in different cases and at different stages, but there is seldom much moist secretion. At the onset in most cases it is probable that the disease begins at the root of the nail. It is sometimes alleged that the rough pushing back of the nail-fold was the cause. When it has once begun, however, there is not much evidence as to its preference for any one part, although, perhaps, throughout the root is preferentially affected. The nail is seldom shed as a whole, but is being reproduced at one part whilst breaking away at another. Patients sometimes describe what appear to be little pus-

Fagge has also given some cases of psoriasis of the nails in the Guy's Hospital Reports, series iii., vol. xv. (1869-70), p. 551, &c. In the same paper are notes on the transverse markings caused by illness. It also contains notes of two very remarkable cases of disease of the finger-ends and nails, in one of which there was chronic enlargement of the ends of the fingers apparently from enlargement of the last phalanx; while in the other, symmetrical disease of certain nails occurred with impaired sensation and circulation in the fingers, and in association with a peculiar thickening of the skin of the face.

tules, which form in the nail-bed and are visible through the transparent nail. These may form at any part, and their usual course is to cause the nail over them to thin and break down.

A peculiar feature of this group of cases is the restriction of the disease through many years to a single finger. Yet it may be suspected that in some instances precisely the same form of disease affects several fingers.

It may be that in some instances there is an infective process, and a tendency sooner or later for the disease in one nail to cause disease in others. The affection being very persistent in spite of treatment, and not infrequently disfiguring, the ultimate measure of excision of the nail is not infrequently resorted to. When this is done a very remarkable pertinacity in the reproduction of fragments of nail-tissue is often preserved. If the least bit of the nail-bed be left behind, a troublesome slip of new nail will be reproduced, and the patient will be disappointed with the result. This circumstance makes it clear that the formative activity of the papillary layer is not materially interfered with, and places the cases in strong contrast with what happens in congenital pemphigus when the nails are affected.

In this group I have to place cases which occur both in children and in adults. One of the most marked was that of a little girl whom, during 1890-91, I saw several times in consultation with Dr. Swallow, of Clapham. We had a portrait taken, which will appear in a future number.

In this instance there was no very definite history of injury, and the part first affected seemed to be definitely the lunula. Dr. Swallow had carefully observed the process, and he told me that little red points visible through the nail would form on the lunula, and the nail, being already very soft in structure from previous disease, would become perforated by what appeared to be a minute abscess. Through the perforation a little mass of granulations would sprout, and subsequently healing would follow. This process was always attended by much tenderness, and having been often repeated, the whole nail had been to a large extent

destroyed and had become thin and fibrous. It was thought that the tendency to the formation of pustules had resulted in smaller ones than those first observed, but that they came more often. The portrait of Miss Smith's nail was taken on April 10th, 1890. I have a subsequent note on October 21st of the same year, which mentions that the little pustules when they break discharge only a drop or two of bloody serum, and not pus. We used a variety of remedies, both local and constitutional, but I am afraid without any great advantage.

Another case very similar to that which I saw with Dr. Swallow was brought to me by Dr. Stivens, the patient again being a little girl, and only one finger being affected. In this instance the nail had already been cut away twice before I saw the patient, but little fragments at its sides were still reproduced.

Affections of Single Nails.

An example of this form of nail disease occurred in a lady named E——, who was sent to me by Mr. Rickards, of Birmingham. She was stout, fair, and florid, and of gouty descent. Her nails were naturally thick and polished (the nails of gout). The nail of her thimble finger, and it alone, was affected. A sort of second nail had formed on the nail-bed, and the original nail had become loose above it. The condition had been present several months when I saw her, and the nail had been twice cut away (by Mr. Barling and Mr. Rickards, at Birmingham). It was supposed that it might originally have been injured by the thimble, but there was no proof of this. The nail was growing again when I saw it. There was no soreness whatever. The nail-bed which was producing the second nail was rough, fibrous, and so hard that I could not scrape the new material away.

It was in October, 1891, that I first saw Mrs. E——, and I saw her only once. Mr. Rickards has been good enough to inform me that her nail got quite well, without being shed, about three months after our consultation, but he was not

able to say whether there had been any subsequent relapse, as the patient had passed from under his observation.

Case illustrating Persistence of Disease after Injury.

An important example of persisting inflammation of the nail-bed and end of finger after a slight injury was afforded by the case of Mrs. M——, who was brought to me by Dr. Phillips, of Croydon. Mrs. M—— was a stout and healthy married lady aged about fifty. It was the middle finger of the left hand which had suffered. The original injury was very slight. Mrs. M—— had been pushing back the nail-fold at the root of the nail with her penknife, and had, as she suspected, “poisoned it.” At any rate a whitlow formed, and the nail loosened and was shed in fragments. This was two years before I saw her, and during that period Mrs. M—— had been under the care of her surgeon. Dr. Phillips told me that he had exhausted all remedies which he could think suitable, but without any permanent good effect. Several times the finger-end had seemed almost well, and then an acute relapse had occurred. The nail had been frequently reproduced, but never in a sound condition. It was always thin and somewhat soft, and much fluted on its surface. Dr. Phillips described the relapses as having been frequently attended by the formation beneath the body of the nail of minute pustules. These were first seen as little red or dusky spots, visible through the nail substance. Over these the nail softened and a little granulation growth protruded. Some of these had been followed by healing, but more usually a relapse of inflammation of the whole end of the finger resulted. Lately these relapses had been attended by extension of erythematous congestion and swelling on the backs of other adjacent fingers, but none of the other nails had been attacked. At the time of Mrs. M——’s visit to me, February, 1899, the whole nail was broken up and the finger-end inflamed. The inflammation of the skin extended at least half an inch round the nail. As the nail was a deformity and a source of much discomfort, I recom-

mended that it should be removed, with great care to make complete excision of the whole of its bed.

*Injury to the Nail—Disease persisting for twenty years—
Production of a Double Nail.*

Rev. Mr. B——. His right thumb-nail is loose from its bed and somewhat opaque. I can pass a probe under it almost to the lunula. It keeps its form and position, and is not thickened. It looks simply opaque, and as if dirty. He complains that it often gets caught, when it gives pain and may bleed. Twenty years ago he had the thumb-end cut off in a bread-cutter and the nail injured. The nail has never looked right since the accident. But the loosening has been extending downwards of later years, and during the last two years has been decidedly worse. The nail has never been shed. He has a second nail under the old one, which he has to cut when he cuts the other.

*Injury to one in a Child who was liable to Eczema—Repeated
Exfoliation of the Nail and subsequent involvement of
others in Psoriasis of Nails.*

My next case is one which appears to illustrate the influence of constitutional predisposition in modifying the results of local injury. To put it otherwise, it may possibly illustrate the effects of local injury in bringing into evidence constitutional tendencies which were otherwise wholly latent.

Miss L——, a child of four, in excellent health, was brought to me on account of disease of the nail on her right ring-finger. It had been present for fifteen or eighteen months, and had followed the crush of the finger by a door. Ever since the injury the end of the finger had been in a state of slight chronic inflammation and the nail had several times exfoliated. There had been neither suppuration nor any material swelling, but the whole nail-bed was inflamed and its borders were red and scaly. At the date of her first visit to me I detached an epidermic crust which looked like a

nail but was not so hard. There was left beneath it a new very soft nail. The skin surrounding the nail was red, dry, and scaly. I first saw Miss L—— on September 18, 1894, and at that date none of the other nails were affected, nor had she any skin disease. Her mother, who came with her, had, however, dry peeling of her palms and sides of fingers which extended to the roots of the nails. It was a very definite condition, though not severe. I was told that the child's father had suffered from eczema, and that his father had had "chalk-gout."

When I saw Miss L—— for a second time, six months later, I was shown a penny-sized patch of eczema-psoriasis, quite dry, on the skin of the abdomen, and the further fact was elicited that in infancy the child had suffered from eczema, as had also several of her brothers and sisters. She still had some eczema behind the ears. A few months later my notes state that the nail first affected had grown again and was almost sound, but that the nail of the middle finger of the other hand was in a condition of "typical psoriasis." That is, that it was beginning to be loose at its free edge and sides with an accumulation of epidermis. In the nail first affected it had begun at the root. In September of 1895 my notes state that two finger-nails of the second hand were now affected and that the patch on the abdomen had relapsed and persisted, but was still solitary. It may be suggested that in this case infective material was supplied by the injured nail which induced the disease in those of the other hand and possibly the patch on the skin. On the other hand, as there was a clear family tendency to eczema-psoriasis, it is of course possible that they may have been independent of each other.

LIST OF DRAWINGS ILLUSTRATING DISEASES OF THE NAILS, Etc., IN MY MUSEUM.

My collection of drawings illustrating diseases of the nails, and contained in the Portfolios of the Clinical Museum in Great Portland Street, comprises the following:—

1. Two fingers showing detachment of the nail from its bed, extending from its free edge backwards, by Miss Green. No name, probably Mrs. C——.

2. The left hand of Harriet Harris, who was under my care in the London Hospital in June of 1878, showing clubbed fingers, as the result, I believe, of thoracic disease. The fingers themselves are thin, but their ends are enlarged and the nails broad. There is no other disease of the nails.

3. Lithographs, showing enormous overgrowth of a nail, probably that of the thumb. No record of source whence taken.

4. Drawing, showing a right hand with destruction of the surface of the nail over the lunula, the rest of the nail being sound. The thumb and middle finger are those most severely affected, and the ring and little fingers appear to be almost if not quite free. This has been figured in the New Sydenham Society's Atlas, and there are duplicates.

5. All the digits of both hands of Mr. M——, aged 22, in 1897. This is my best example of nails detached from their matrix—psoriasis of the nails. The patient was shown at the Congress, and his case is published in ARCHIVES, Vol. VIII. He had no skin disease, but his father was the subject of psoriasis. The drawing is unfortunately not very successful.

6. The right hand, with one finger from the other, of Mr. S——, August 9, 1895. This is an example of the destruction of the nails from inflammation beginning at the lunula and implicating in the first instance the middle of the nail. In association with lichen planus. Full notes.

7. The right hand of Mr. M——, showing disease of the nails of all the digits excepting the index. The distal halves of the nails have

PLATE XXXI.

SYMMETRICAL GANGRENE OF EXTREMITIES, PRECEDED
BY RAYNAUD'S PHENOMENA AND RESULTING IN A
SLIGHT FORM OF SCLERODERMIA.

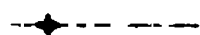
Shows the condition of gangrene in the hand of Miss F——. It will be seen that the end of the left index finger is in a condition of gangrene. The finger is not mummified, but moist, and the proximal portion is distinctly swollen. On a subsequent occasion, a year or two later, the other finger passed into a precisely similar condition. There was on this occasion decided inflammation of the hand, and bullæ formed on the adjacent parts. After the gangrenous part separated the ulcer healed well. Attention is specially asked to the fact that in this case the fingers had not become slender and wooden, but retained a moderate degree of plumpness.

The case partook more of the nature of Raynaud's disease than of sclerodermia, but it is to be remembered that the patient's face was in the condition of the latter malady. There can be no doubt that the two are sometimes combined.

Miss F——'s case is given in detail in 'Archives,' vol. ii., page 88.

PLATE XXXI.

THE EFFECT OF EXTREMITY LESIONS ON
SCURF AND ON THE RESULTING
SCURF DERMATITIS.



The following is a description of the condition of the hand of Miss F. The condition of the left index finger is in a condition of inflammation, but moist, and is not ulcerated. On a subsequent occasion the index finger passed into a precisely similar condition, and this occasion decided inflammation of the adjacent parts. After the ulcer healed well. Attention should be given to the fact that in this case the fingers became swollen, but retained a moderate degree of mobility. The nature of Raynaud's disease is to be remembered, that the patient is not cured by the latter remedy. There can be no doubt that the combined treatment given in detail in 'Archives,' vol. 1, p. 100, is the only one that can be given.

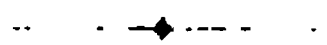
PLATE XXXII.

ACRO-ASPHYXIA (RAYNAUD'S PHENOMENA)

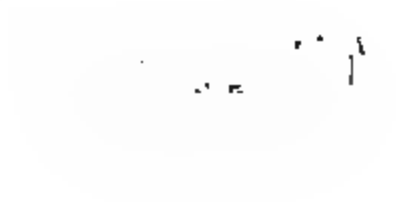
In this portrait is shown the hand of a young lady who suffered habitually from a very feeble circulation. Whenever she was exposed to any degree of cold, her hands became livid, and would remain so for days together. The degree of blueness has hardly been sufficiently marked by the artist, since on the day on which the portrait was taken they were not at their worst. On several occasions I saw the hands so livid as to suggest anxiety lest gangrene might occur. None was, however, ever produced. This condition may be regarded as the simplest, most common, and least severe of the forms of what is known as Raynaud's Disease. Its main feature is a lifelong, and constantly present, excess of susceptibility to the influence of cold, with the result, not of pallor (*digiti mortui*), but of asphyxia and blueness. These cases differ from the forms in which Acro-sphacelus is threatened in that paroxysmal exacerbations are far less marked. The liability is a constant one, and, having once been developed, usually persists through life.

PLATE XXXII

ACROASPHYXIA RAYNAUD'S PHENOMENON



The photograph shows the hand of a young lady, apparently from a very cold circulation. When she was placed to any degree of cold, her hands became stiff and numb, and so for days together. The degree of bruisings had been abundantly marked by the artist, since on the day on which the photograph was taken they were not at their worst. On several occasions I saw the fingers so stiff as to suggest an amputation might occur. Now, why, however, ever and anon, could they may be regarded as the simplest, most common form of the fingers of what is known as Raynaud's disease? It is more frequent, it is frequent, and constantly present, excepting only to the fingers of cold, with the loss of, not only the fingers but of the fingers and blue color. These cases differ from the forms in which Acroasphyxia is threatened in that the fingers are far less marked. The liability is constant one, and, having once been developed, usually permanent.



!

broken away, leaving abrupt edges undermined for a short distance. The lunula and adjacent parts are still healthy. Evidently a severe form of common psoriasis of nails. The thumb-nail has suffered most, but even in it the lunula is still normal.

8. The left hand of Mrs. C——. She inherited gout and was the subject of very extensive common psoriasis. In some parts, and especially on her digits, the conditions resembled eczema. Her nails presented a mixed form of disease, being in part loosened at their free edges, but being also inflamed at their roots with implication of the lunula. This drawing has been reproduced for *ARCHIVES*, but not yet used.

9. Plate L. of *ARCHIVES* illustrates acro-dermatitis, with disease of the nails (see page 251, Vol. II., of *ARCHIVES*). The patient was an old man, whose circulation was feeble, who had formerly suffered from frost-bite, and who still continued to expose his hands to cold and wet.

10. Copied as Plate XXXII. of *ARCHIVES*, illustrates the dusky condition of the nails in a young lady who suffered from very feeble circulation and from mild paroxysms of Raynaud's malady. This portrait offers a good example of the opaque white spots so often seen in the substance of nails.

11. Copied as Plate XXXI., shows the condition of the nails in a case of severe Raynaud, which had produced gangrene of the end of one digit. The patient's case (Miss F——) is published in *ARCHIVES*, Vol. II., page 88. The nails are seen to be striated, opaque, and fibrous-looking.

12. The right hand of Eric W——, aged 8 years, May 12, 1897, by Miss Green. The condition shown is that of eczema of the ends of the digits, with implication of the nails at their roots and sides. Narrative of case prepared for press. The nails are both loosened at their sides and roughened on their surface.

13. A drawing by Miss Green, dated March, 1895, but without name, showing the ends of the digits of both hands, probably of a woman. The nails are thin, fibrous, and discoloured, and broken away at their free edges.

14. An illustration of chronic onychitis of one nail only. The patient, Miss McI——, was aged 18 in April, 1891. The nail of her right index finger had become fibrous and broken up, and, being a source of disfigurement and having persisted for a course of several years, the nail-bed had been twice cut away. Portions of nail were still, however, produced, and a third excision taking the surface of the phalanx had to be performed.

15. A lithograph from Dr. Payne's paper on pemphigus in a child.

Some of the nails were destroyed and others converted into solid claw-like structures (see St. Thomas's Hospital Reports, Vol. XII.).

16. A photograph given me by Dr. Woods Hutchinson, showing disease of some of the finger-nails in a lady. The nails have become fibrous, thickened, and broken, the disease apparently commencing at the lunula. In the right hand the index, middle, and little fingers are affected, but in the left hand only the little finger. The condition had persisted for some time.

17. Two photographs given me by the late Mr. Simpson, of Lincoln, showing disease of the nails which was believed to have been congenital. The nails were loosened from their matrix and stood up at a distance from it. They were much thickened and almost fleshy, exuding fluid when cut. They were strongly curved from side to side, and almost claw-like. In the nails of the toes the same conditions were present, but to a less degree.

18. Plate XXII. shows a secondary implication of the nails in association with severe chronic eczema of the ends of the digits.

19. Copied as Plate XVII., illustrates the atrophic destruction of nails which sometimes attends morphaea with Raynaud's phenomena.

20. The hand of Miss U——, a young lady of 17, who was the subject of chronic eczema in patches. One patch involved the cleft between the thumb and forefinger, and another the end of the thumb; and she had formerly suffered from intertrigo in the axillæ and popliteal spaces. It was a mixed form of skin disease, between psoriasis and eczema, and she had been accustomed to relapses every spring for ten years. The skin around the roots of the nails was wont to become inflamed, and the surface of the nail rugged.

21. Drawing showing favous growth under the nails of a man. This is copied from one in the collection of the Leeds Infirmary, and was done by Mr. J. W. Haigh in 1898. The thumb and the middle finger of the left hand and the index of the right are those affected, and the drawing appears to represent detachment of the nail by the growth of a favous crust under it.

22. Florence H——, aged 12. This girl had been for nearly a year the subject of chronic eczema of her hands. Her nails were implicated on their surfaces, and had become rugged with transverse ridges. The condition was fairly symmetrical, and almost all the digits were affected. There are two drawings, one in oils.

23.—A portrait of both hands of a man, by Burgess. The nails are discoloured and appear to be loose at their free edges. Those of the

PLATE CXXXVIII.

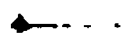
FLUTING OF THE NAIL BEGINNING AT THE LUNULA.



THIS portrait illustrates a form of disease in which the disturbance of nutrition begins at the lunula and produces longitudinal ridges which run up the middle of the nail. For some time the sides of the nail remain smooth, but in the end they are involved also. The ridges are often very firm, and there is not much tendency to breaking up of the structure. The condition is not attended by any other inconvenience than its unsightliness. After lasting for many years it finally leads to destruction of the nail, with the prolongation forwards upon its bed of a fan-shaped web of the nail-fold (pterygium of the nail-bed). In the present Plate the artist has not succeeded in showing with sufficient clearness the comparative escape of the sides of the nail.

PLATE CXXXVIII.

PLATE OF THE NAIL BEGINNING AT THE NAIL-FOLD.



This is a form of disease in which a nail-fold
is at the base of the nail, and produces a
growth which runs up the middle of the nail. For some
time the nail remains smooth, but in the end the
growth becomes very firm, and there is a
tendency to the formation of the structure. The condition is
attended by no more inconvenience than its appearance, and
lasting for many years it finally leads to destruction of the nail.
with the growth of the nail-fold upon its head. A few specimens of
the nail-fold (epithelium) of the nail-body. In the present
the artist has not succeeded in showing with sufficient clear-
ness the comparative growth of the sides of the nail.

thumbs are lifted up by an accumulation of epidermis under them. I have mislaid the reference to this case, and do not for the present know whose hands they represent.

24. Nails, showing transverse furrows in association with eczema of the ends of the digits (figured in New Sydenham Society's Atlas). There is another portrait showing the eczema of the palmar surfaces.

25. The two hands of Mr. C——, March 10, 1897. He was the subject of chronic eczema, and his child also had it. For this he attended one of my demonstrations, when we noticed the most unusual condition of his nails. The proximal halves of the nails had become white, the condition resembling an enormous lunula, but extending from side to side, and showing but slightly-marked convexity of its edge. He thought that the condition was increasing, but this was doubtful. The question was whether it was congenital or an example of an advancing canities unguium. He was a man of only middle-age.

26. The right hand of Mr. H——, August 2, 1894, showing disease commencing at the lunula and running forwards in the middle of the nail, but finally involving almost the whole of it. Reproduced for ARCHIVES, but not yet used.

27. Onychia maligna, two fingers of a child, one of them showing much swelling at the end of the fingers, with the destruction of the nail and ulceration of the nail-bed.

28. Onychia maligna, the hand of a child, the middle finger being affected with this form of onychia (figured in New Sydenham Society's Atlas).

29. The left great toe and the left thumb of Mrs. P——, æt. 69, September, 1890. These two digits were the only ones affected, and in each the nail-bed had inflamed and loosened the nail. From the toe the nail had been removed, but it was still present on the thumb. Probably an incomplete form of acute psoriasis of nails, and to be compared with Mr. Hearndon's patient.

30. The index finger of Dr. W. J——, aged 22, showing a primary sore involving the root of the nail (by Burgess).

31. Portrait showing the five digits of the right hand of a man, showing loosening of the nail from its bed, beginning at the free edge and extending backwards, with some breaking up of the surface of the nail. The little finger is the only one of the digits which has escaped. There are lithographs of this, and it is given in the New Sydenham Society's Atlas.

32. The hand of an infant subject to specific disease, showing the

nails convex, as if pinched, the conditions being most marked at the nail root (published in the New Sydenham Society's Atlas).

83. The thumb and two fingers of Mr. R——, a surgeon. The middle finger shows the condition of the nail six months after a primary chancre of the finger.

84. The finger nails of an infant suffering from specific disease. The conditions are those of psoriasis chiefly, *i.e.*, loosening of the nail from its bed, beginning at the free margin. The pinching up of the nail present in portrait No. 82 is not shown.

85. Coloured portrait showing the condition of the nails in a woman who was sent to me from the Queen's Square Hospital, June 1, 1898, by Dr. Hughlings Jackson. The patient had been hemiplegic for a year and eight months. The sketch shows a transverse bar of blood-staining crossing all the nails just below their free edge. This bar is in exactly the same position in all. Below it, at similar distances on all, are seen transverse furrows. It seemed probable that ecchymosis into the nail had occurred formerly and gradually travelled forwards, but the history was indefinite, and it was not certain that the staining was really blood. The patient's memory was very feeble.

Since the above was written I have been informed by Dr. Purves Stewart that before the patient left the Hospital the ecchymotic (?) bar had been quite removed by the onward growth of the nails and that the nails appeared quite normal. The affection had involved both hands, but that of the hemiplegic side more severely than the other. The woman's name was Clara Bearman.

86. A photograph taken at the Clinical Museum, June, 1898, showing the nails of Mr. ——. The thumb nails are most severely affected, and next the middle and ring fingers on the right hand, and the middle finger only on the left. The little finger and the index finger on both hands have escaped, and the ring finger also on the right hand. The condition is a fibrous breaking-up of the nail substance, involving the anterior three-quarters or even the whole of the nail.

PLATE XVII.

ACRO-SCLERODERMIA: A LATE STAGE OF SCLERODERMIA OR DIFFUSE MORPHŒA.

THE hands shown in this Plate offer a good example of the atrophic condition of diffuse morphœa or sclerodermia. The fingers have lost all plumpness, and become slender, pale, and wooden. The greater part of the hand is of wax-like pallor, but there are numerous patches of congestion (stigmata), like red seaweed, and here and there are a few little ulcers. It was quite impossible to pinch the skin up anywhere, as it was tight and parchment-like. Although there had been no gangrene of appreciable extent, the nails and tips of the fingers had suffered more or less. It is worth while to look carefully at the portrait, and note how symmetrical the changes are. Another view of the same hands is given in Plate XXXI. It will be seen that the thumb has almost escaped (probably on account of its shortness); that the index and middle finger have suffered more than the ring; and that the little finger has had its terminal phalanx twisted and flexed. This form of morphœa is always especially severe in the hands and face, and may on that account be appropriately described by the prefix "*acro*." Its subjects are always liable to Raynaud's phenomena; but, on the other hand, it is by no means true that these phenomena produce sclerodermia.



PLATE XVII.

ACROSCLERODERMA AT A LATE STAGE OF DEVELOPMENT, OR DIFFUSE MORPHEA.



The hand shown in this Plate is a good example of a strong evolution of diffuse morphea or scleroderma. The face is almost lost and prominent, and becomes stiff and pale, as was seen. The greater part of the hand is of wax-like paleness, and there are no large patches of congestion (signa) here and there, and here and there are a few little ulcers. It was impossible to pinch the skin up anywhere, as it was like the skin of a mummy. Although there had been no gangrene of any extent, the nails and tips of the fingers had suffered considerably. It is worth while to look carefully at the picture, and note how symmetrical the changes are. Another view of the hand is given in Plate XXXI. It will be seen that the thumb has almost escaped (probably on account of its shortness); that the index and middle finger have suffered more than the ring; and that the little finger has had its terminal phalanx twisted and retracted. This form of morphea is always especially severe in the hands and face, and may on that account be appropriately described by the prefix "*acro*." Its subjects are always liable to Raynaud's phenomena; but, on the other hand, it is by no means true that these phenomena produce scleroderma.

WAS SYPHILIS A NEW DISEASE IN EUROPE IN THE SIXTEENTH CENTURY?

A STRONG argument which may, I think, be urged against the belief that syphilis existed in Europe before the return of Columbus' crews from America is that, if it had been present at all, it must have prevailed extensively. It is not in the nature of things that there should have been only a few cases, one here and one there. The sexual morality of the age was not in the least better than that of our own, and the social habits as regards crowding and personal intercourse were far more likely to have favoured its spread than in our own times. Yet the mention of affections which may be supposed to have been syphilitic are few and vague, and nowhere is it spoken of as a common malady. In the present day it is not possible, excepting in connection with the movement of armies and as a quite local affair, to conceive of syphilis spreading as an epidemic. It is now generally diffused, and those sections of the population likely to be exposed to risk regularly from year to year furnish their quota of cases. A very large majority are almost wholly prevented by social habits and moral laws from encountering any risk whatever. Nothing short of a complete *bouleversement* in these matters could possibly permit syphilis to overrun Europe as an epidemic. Yet in the close of the fifteenth century it did so prevail, and to the astonishment of the communities whom it affected. Nothing whatever had occurred apart from the movement of armies (which was no new thing) to explain such epidemic prevalence. The evidence is that everywhere it was regarded as a new disease, and that it was not understood. Not only the public, but the doctors, were puzzled. It was soon

found to be contagious, but it was not for some little time that it came to be regarded as in the main a sexual matter, and as involving more or less of discredit.

The inference from these facts that it was really a new disease seems very strong.

Some writers, Hirsch amongst them, who have laid most stress on the "epidemic" character of the post-Columbian outbreak have insisted that it not only began suddenly, but subsided quickly, as if it were comparable to influenza or plague. A moment's consideration of the probabilities will, however, convince us that nothing of this kind is possible in connection with such a disease as syphilis. Its wide prevalence could only conduce to a still wider spread subject only to the controlling influence of two factors. These factors are, that the disease protects those who have suffered from it from second attacks; and next that observations of its contagiousness would lead to precautions.* These well explain all that is recorded as to the subsidence of the syphilis-epidemic. It had come suddenly, and whilst suitable material existed it had prevailed extensively, but, the material being exhausted, it had subsided. It had, however, unfortunately, although no longer epidemic, come to stay.

It is one of the most attractive features in the pursuit of the medical profession that it increases a man's interest in all departments of knowledge. Not only the sciences more directly collateral with medicine, but such topics as race-descent, geography, geology, and general history, assume for him a new importance. To him there is but little that comes amiss, for he can scarcely open a book or take up a newspaper without finding that he has gained some item of information which can be put to use in his own vocation.

At the present time there are two periods of history which appear to me to be especially attractive. The one is the social history of Europe during the general prevalence of Leprosy, and its subsequently scarcely less general decline; and the other, that of the last decennium of the fifteenth century, during which Syphilis spread as an epidemic and when it was

* It is related that Mary Queen of Scots refused to allow her infant son at his baptism to be kissed by a "pocken priest."

not improbably a wholly new disease. Although the main facts as regards the prevalence and decline of Leprosy might be briefly summarised, they would yet need a good deal of explanatory corroboration, and I must for the present be content to commend the subject to the attention of any of my more leisured readers who may incline to pursue it. Respecting the Advent of Syphilis I have a few words to say, for, as stated above, a novel aspect of the question has recently dawned upon my mind. Hitherto I have been inclined to rather indolently pass the matter over, and to assume from the allusions to venereal diseases which are found in old authors, that syphilis itself had been in Europe from time immemorial, and that there was no reason whatever to suppose that it was brought from the West Indies by Columbus' sailors. My recent studies of Yaws, which have resulted in a firm conviction that it is the parent form of syphilis, or, in other words, syphilis modified by race and climate, have, however, added new interest to the subject, and given it an aspect of much practical importance. At the same time it has added probability to the story that the sailors in question did really contract the disease and bring it across the sea to their countrymen in Europe. It is on record that a disease of this kind was found to prevail amongst the aborigines, and that some of the Spaniards were infected by them. It is also well known that Yaws does at the present time prevail largely on those islands. The further fact is admitted by all, that directly after the return of Columbus true syphilis began to prevail, taking its start from Spain, Italy, and France, and travelling northward. That there was a most conspicuous prevalence of it—"an epidemic"—and that to most persons it appeared to be a new disease, no one can doubt. It was supposed to have been carried from Italy to France by the soldiers of Charles VIII. on their return from his invasion of that country. Here, however, precise dates become of great importance, for the weak point in the argument of those who hold to the importation-hypothesis is that the epidemic was observed within a year or two, or possibly even just before Columbus' return, and that it was perhaps noticed in

Paris before the return of Charles' soldiers. Some of those who have written on the subject have not been quite sufficiently careful. Thus Dr. Berdoe, in his "Popular History of Medicine," writes of syphilis: "It appeared with such violence and frequency in the year 1490 in France, Italy, and Spain, that the scourge was considered to have only then been introduced from America." In accepting this as testimony to its apparent novelty, it must be pointed out that there is some error as to dates. Either the epidemic was later than 1490, or it could not possibly have come from America, for Columbus' ships did not return till 1493.

As regards Columbus the real dates are, I believe, that he sailed on his first voyage August 3, 1492; landed on one of the Bahamas on October 12, and after remaining some weeks, was in Spain again in March, 1493. He sailed on his second voyage in September, 1493, and from this time onward there was increasingly frequent communication between the two continents.

Now the dates as to Charles VIII.'s invasion of Italy are as follows: He was in Naples in 1494, and commenced his return in 1495, reaching Paris in 1496.

It is of much interest to determine the exact dates at which syphilis began to attract attention in the several states of Europe. Turner writes respecting France that in the year 1495, which was less than two years after the expedition to Naples, "We find it so terribly raging that an edict was published to confine the infected and proscribe their converse with other people." It is perhaps an assumption on Turner's part that it was "terribly raging," for if it prevailed amongst a comparatively limited number of courtiers and soldiers just returned from Naples, and was recognised as the new Neapolitan malady, that may have been quite sufficient to excite alarm. Otherwise the date given would be almost conclusive against the Columbian hypothesis, for such a disease introduced into Spain in 1493 would not be likely to be so "terribly raging" in Paris in 1495 as to require laws for its repression. Turner's dates are, however, not very exact, for, as we have seen, Charles VIII. did not return from Italy till 1495, and did not reach Paris till 1496.

Dean Kitchin, in his recent history of France, writes: "The poor remnants of his army, bringing with them the seeds of loathsome contagious diseases, found their way back to France in 1496." Evidently Kitchin knows nothing of any repressive law in 1495.

I find that both Sydenham in the seventeenth century and Daniel Turner writing in 1724, entirely anticipate my recent statement that Yaws is probably the parent form of European syphilis. Sydenham, however, believed it imported from Africa. Turner writes: "The last of these authors, Sydenham, thinks it, however, brought from Guinea, in Africa, where it is endemial if not indigenous, as the scorbutus to Holland, and the rhachitis to our island, but is there called by the name of Yaws, as I have heard the captain of a ship who has frequently made that voyage." "The Spaniards," saith this gentleman, "were the persons first infected by the blacks or slaves bought up in Guinea; and by their means that cursed plague was transplanted and hath since grown up with us, as a just punishment (some say) for that barbarous practice of trafficking or making merchandise with our fellow-creatures."

Turner goes on to quote from Thevet Cosmog, lib. 3, cap. 2: "In utraque viâ Fluvii Senegæ. . . . Morbus qui illic frequentius grassatur Borozaïl nominatur aut Zail Æthiopian lingua qui ex immodica venere ortum habet."

The west coast of tropical Africa known as "Guinea" had been visited freely by Europeans (Portuguese and French) during the fifteenth century, and as Yaws was probably endemic there as well as in the West Indies it is obvious that in asking the question as to its being a new disease in Europe towards the end of that century we are not restricted to the supposition that it was imported by Columbus. It may have come both from Africa and America, and its introduction from the former may have been some years earlier than from the latter. This is not at all improbable, and we may therefore, without any further reference to the dates just given, discuss the all important question, Was it probably a new disease? I have said that a new argument

has occurred to my mind on this point which seems to me to have great force. It is this, that having regard to the nature of syphilis, the modes of its contagion, and the habits of the age, it is incredible that anything of the nature of an epidemic could have occurred unless the virus were a new introduction. We must bear in mind that the epidemic was not a local one; it did not involve only districts visited by armies, nor was it confined to courts. It spread over all Europe, and, what is not less remarkable, in the course of a half-century it was found to have declined. Now this is precisely what we should expect if the disease were introduced into a virgin population ignorant of its nature and adopting, in the first instance, no precautions. Both the epidemic prevalence and the decline would have been alike impossible if the disease had been extant in the same regions previously. Had it been so, it would have been a matter of common knowledge that the malady was contagious, and it would have become, as it is now, incident in the main only to those unwilling or unable to restrain the sexual appetite. It would have become, as it is now, a venereal disease instead of being, as it was then, propagated by other and quite accidental modes of contagion. The virus of syphilis cannot, like those of the fevers, be conveyed without contact, and amongst people who knew its nature it could not have become epidemic. There was nothing in the social habits of the fourteenth and fifteenth centuries—the morality, the cleanliness, the care and use of utensils, the avoidance of crowding, &c.—to have prevented syphilis from spreading in them as it did in the sixteenth if its virus had been extant. Dr. Creighton (in the “*Encyclopædia Brit.*,” vol. xviii.) writes: “Its enormous prevalence in modern times dates without doubt from the European libertinism of the latter part of the fifteenth century.” So far, however, as I know, there is not the slightest reason to believe that any wave of libertinism passed over Europe at that period spreading from north to south and involving all classes in its effects. Sexual morality is not a matter prone to vary much through large communities. We may, it is very true, have a moral court or an immoral one, but such differences

have probably but little effect upon the people at large. At no period during the middle ages, nor indeed since, has sexual morality been such in itself as to prevent the spread of syphilis, and there is probably no reason whatever for attaching any special stigma to the close of the fifteenth century. Nor in fact, as has been already suggested, was the epidemic spread of syphilis in any very special manner connected with sexual libertinism. It spread in the main by accidental modes of contagion, and only after a certain duration did it settle down into a sexual disease. Those who think that there was anything special in the moral laxity of the times will find it very difficult to explain the subsidence of the epidemic during the next half-century. That it did decline we have unanimous testimony. On the supposition that it was a novelty we can easily explain this, for a large number of persons would have become immune and all would have become careful. That there was any general improvement in morals we have not the slightest proof. Had the decline occurred in the middle of the next century, the age of Puritanism, there might, so far as England was concerned, have been some plausibility in the suggestion; yet even then we must remember that Cromwell's army advancing into Scotland was responsible for local outbreaks of syphilis.*

The facts above stated make it, I think, improbable in a very high degree that syphilis could have existed in Europe before the great outbreak in the end of the fifteenth century. There remains, however, to be adverted to another kind of evidence, the supposed allusions to it by medical writers prior to that date. It is supposed that Celsus described it and that some of the Greek and Roman poets referred to it. It is admitted, however, on all hands that such references are fragmentary and vague. None of them approach in force the words which Shakespeare has put into the mouth of Timon. Now if syphilis existed at all in the times of Greece and Rome, it must have become very prevalent, for there was nothing in the moral law to prevent it from doing

* See ARCHIVES, Vol. VIII. p. 23, "Framboesia Cromwelliana."

so. It is incredible that if the English people were now to be placed under social laws as to sexual continence as lax as were those of the nations referred to, that syphilis should not become an almost universal malady. It could not possibly have been overlooked; it could not possibly have failed to attract the attention, not only of physicians, but of moral censors and of law makers. There could have been no mistake about it; nor could it have escaped attention that the disease spread by other modes of contagion. Yet of all this we find almost nothing. Medical writers described diseases of the genitals but did not write about venereal maladies as such.

Let us imagine syphilis wholly absent from England. Surgeons would still take note of balanitis, of herpes, of urethral discharges and of cancer of the organs. Dealing with these topics they would write just such chapters as Celsus and others wrote. Some have fancied that Celsus knew the characteristics of the indurated sore, but the expressions which he uses seem to me far more applicable to epithelioma. I repeat it is impossible that syphilis, if present at all, could have occurred only as a rare disease. If the physicians of the day knew anything of it they must have known all, and it is quite clear that they did not. The same argument applies to the literature of the day. If either syphilis or gonorrhœa were extant in Italy and England at the time they wrote, it is inconceivable that such writers as Petrarch, Boccaccio, and Chaucer should make no reference to them.

DISEASES OF THE SKIN.

No. CX—*Subcutaneous Indurations in the Diffuse form of Morphœa.*

Amongst the cases brought by Mr. Hitchens to our demonstration on March 22nd was one of extreme value in illustration of that peculiar form of sclerodermia in which the cellular tissue rather than the skin itself is involved. The patient was a married woman, aged about thirty-five, who had attended on a previous occasion. Her face bore a very remarkable resemblance to that of Mrs. Moore,* who has been the subject of many demonstrations as an example of diffuse morphœa, with Raynaud's phenomena and gangrene of the ends of the digits. I mention this in order to show that the cases were essentially the same. But in the case of Mrs. Moore there were none of the subcutaneous indurations which I am about to describe. The face resemblance consisted in the fact that both women were florid, with tendency to stigmata on the cheeks, that in both the features looked somewhat pinched and drawn, the nose especially being thin and a little glossy, and the upper lip being somewhat stretched so as to habitually expose the teeth. Both patients were quite conscious of a certain difficulty in keeping the lips closed, and of a degree of stiff-

* Mrs. Moore's case is published at length in my Clinical Lectures, Vol. I. p. 340.

ness in them. In Mrs. M——'s case rigidity of the cheeks—"unpinchability," as it has been called—was a very marked feature. In the case now under consideration it was much less so; indeed it might almost have been doubted whether the cheeks were hard at all. I feel, however, no doubt that they were so in slight degree, more especially in the regions just in front of the ears. The patient described very definitely daily recurring attacks of asphyxia of her hands, but they had never been sufficiently severe to threaten gangrene or to cause ulceration.

It could not be said that her digits were wooden, yet the skin was certainly a little stiff and unduly pale, and the nails were brittle and broken. Extending up her forearms were very ill-defined patches of pale and slightly stiffened skin, with slight mottled congestion. Similar conditions were present on her legs. On the neck and chest the skin was perfectly soft, supple, and healthy, and there was a fair amount of subcutaneous fat. Thus it will be seen that the case fits exactly with others of the group sclerodermia, differing from them mainly in the circumstance that the conditions were only slightly marked. They were, however, quite definite. We now come to the more important part of the case. Upon the outer parts of the thighs, extending from a little below the anterior superior spine nearly to the knee, and placed quite symmetrically, were somewhat ill-defined thick masses of induration in cellular tissue. The skin was involved in being in most parts inseparably merged in the induration, but it did not appear to have been primarily affected, and near to the margin of the patches it was certainly movable over cellular tissue which was almost as hard as bone. In the middle of the patches there was distinct depression, as if by contraction of the subcutaneous tissues. The skin over these indurations was pale for the most part, but did not show any resemblance to the ivory patch. At the upper part there were some little rounded nodules of induration in a group. The patient still retained very fair health, and no special illness had preceded the development of the sclerodermia.

No. CXI.—*On the Relationship between Xerodermia and Psoriasis (Transmutation in Transmission).*

A boy who was sent to me by Dr. Alfred Duckworth, of Croston, afforded a good example of the form of eczema to which those born with congenital xerodermia are liable, and at the same time of the laws of inheritance. He was a finely developed lad of five years of age. His face was florid and clear, but his forehead and some other parts were covered with a form of lichenoid eczema which showed numerous little blood crusts from scratching. There was no thickening of the skin, nor did the eczema appear to show any tendency to spread.

The history was that he had had several attacks of eczema, some of them much worse than the present one, and that they generally came on his face during cold weather. He had been under much treatment during the last four years. Dr. Duckworth had throughout referred the eczema to the congenital peculiarity of the boy's skin, and in this no doubt he was quite correct. The boy was the subject of universal lichenoid xerodermia, and was said to scarcely ever perspire. The condition attained its maximum on the tips of his elbows and adjacent parts of back of forearms. Here the condition might have been taken for one of psoriasis. It did not, however, exactly simulate the latter, for the patches were simply rough and dry, and had no abruptly margined edges.

The facts in the family history were these: The boy's mother herself was the subject of a similar condition of skin, though in very much slighter degree. She had always experienced difficulty in perspiration. Of his four brothers and sisters, none of them presented anything definite in the direction of xerodermia. A maternal uncle had suffered very severely from what had been called psoriasis during most of his life. In the boy himself the condition of his skin had been noticed when he was only a day old. His mother assured me that his skin appeared to give him but little discomfort, and that he could take exercise well. She

said that hot weather suited him best. Emollient applications were constantly used.

No. CXII.—*A peculiar form of persistent Urticarious Dermatitis which has become pustular and more or less universal.*

I saw at the Lowestoft Infirmary a patient who was the subject of a somewhat peculiar form of what might be called pustular urticaria. Mr. Walker, of Lowestoft, who showed me the case, and under whom the man was, told me that it began distinctly as urticaria. This was about three years ago, the patient being then apparently in good health, and a man of about 35. From that time to the present the eruption had never been cured, though a great variety of remedies had been tried. It had always been better in warm weather and worse in cold, but never really well even in the height of summer. When I saw the man (September 4, 1891) his trunk and limbs were covered with a mixed eruption, which consisted of irregularly placed stains, papules, and pustules. It had been very much scratched, and many of the papules showed abrasions. The pustules were attended with a good deal of irregular and ill-defined thickening at their bases. There had never been any bullæ, nor was the primary type of the eruption pustular. It appeared rather to have been an ill-defined and irregular papular eruption. The eruption occurred chiefly on the parts covered by clothing, and exempted his face and for the most part his hands. It was severe on his thighs and legs. There had been some swelling of the glands in Scarpa's triangle, but at the time I saw him (midsummer) it had a good deal subsided. The skin generally was dry and harsh. The eruption had made the poor fellow's life miserable to him; he was almost disabled from occupation, and expressed himself as willing to leave the town and try a change of climate, or do anything whatever which might promise him relief. As regards scratching, he said it was quite impossible to avoid it. He was not aware that any articles of food made him worse.

This case seemed to me very likely to end in conditions similar to those displayed in that of Colonel F—G—. The pruriginous element in this last has, however, been definitely characterised by urticaria.

To the above notes, which I wrote out after returning from Lowestoft, Mr. Walker has been good enough to add the following:—

Four years ago he had an eruption on his back which he was told was nettle-rash, and which yielded at once to aperients and alkaline baths. This was in November. In the same month three years ago he had a papular eruption, which first appeared on the back between the shoulders, and which soon became mixed with raised white patches upon a violet-tinted base with red areola. It was intensely itchy. Rubbing increased the eruption, and if any part of his skin itched and he rubbed it he could bring out the eruption. A large patch soon appeared on the front of the left thigh, and others continued to appear until finally every part of his body was more or less affected. His face has frequently been attacked, his eyelids becoming puffy and the whole face presenting a swollen, urticarial appearance. His legs and back have suffered most, and whenever a north-east wind blows for a couple of days he gets an acute general outbreak of urticarial eruption. His hamstring muscles tend to contract, so that he has difficulty in straightening his legs in the morning after a night's rest. The eruption did not begin to be pustular until a year and a half after its appearance, and now it comes in large patches, which quickly suppurate and discharge — the urticarial wheals being fewer, but the sensation of tingling, burning pain remaining the same, whilst the itching is "terrific." Exercise seems to relieve him, and at night he walks about his room and gains relief in that way; so that he has walked until he has dropped down from exhaustion, and found himself asleep on the floor. He is a man of nervous, irritable temperament. His father died of softening of the brain, but all his four grand-parents lived to be over ninety years of age. There is no special family history of skin disease.

No. CXIII.—*A Peculiar Form of Herpetic
Balanitis.*

Sir W. O. E——, a healthy married man with a large healthy family, showed me a very peculiar condition of his glans penis. He said that he had for more than thirty years been liable to what his doctors had called “herpes” on the part. It did not appear that he had had more than five or six attacks during the whole of that time, but he described one or two of them as having been attended by severe ulceration. He admitted having had gonorrhœa before the first attack of herpes, but did not think that he had ever had any external sore. It remained, however, possible that the so-called herpes might have been from venereal contagion. At any rate he had never had any constitutional symptoms of syphilis, nor any swelling of the inguinal glands. He had married young, and was now about 60, all his children being grown up. The left half of his glans was in a condition of thin white scar, and his prepuce adhered to the corona over almost the whole of the latter, with little pockets here and there. I thought that this might probably be a congenital condition, but he assured me that it was not, and that it had been gradually increasing with each attack of his “herpes.” The condition reminded me of the obliteration of the palpebral sulci which occurs in pemphigus of the conjunctiva. The scar on the glans had extended to the meatus, and the latter was almost closed by a very delicate membrane which I easily broke down by means of a conical bougie. Sir W. E—— had always been most careful in washing, and had found vaseline the most useful application when the part was inflamed. He had recently passed through an attack of herpes, and some little ulcerations were scarcely healed. He had never had any form of skin disease.

No. CXIV.—*A single very superficial patch of Lupus Vulgaris in the middle of one cheek (Miss Herbert group).*

Mrs. S——, a German, aged 49, presented a very thin, dusky brown patch of lupus vulgaris exactly over the flush patch, and much like that in Miss Herbert's case (see Plate X.). It was, however, much thinner than in that instance, being little more than a brown apple jelly-like patch without appreciable swelling. In the middle it had recently become abraded. She said that it had been slowly spreading at its edge for two years. She knew of no cause.

Mrs. S—— was a very thin woman, and she had the two peculiarities of being freckled and stigmatised almost like Kaposi's malady, and that there were chronic sores at the corners of her mouth. I could obtain no history of tubercular disease in relatives, but she had suffered much from chilblains.

I saw Mrs. S—— on September 17, 1896, and applied nitric acid very freely to the patch and also to the commissures of mouth.

Mrs. S—— remained under my observation eighteen months or more after the above notes were written. In spite of repeated cauterisations the patches slowly spread.

No. CXV.—*On cases of Psoriasis which threaten to involve the entire surface.*

There are cases of psoriasis so extensive as to become almost an universal dermatitis. The diagnosis is often missed in this stage, but it may usually be made by observing that there still remain a few irregular areas of quite healthy skin. These prove that the extension has been from the borders of patches which have coalesced, and that the original affection was not a diffuse dermatitis.

An excellent example of psoriasis of almost lifelong dura-

tion, steadily aggressive, and becoming in the end almost universal, was presented in the case of Dr. G——. This gentleman consulted me for the first time when in the most advanced stage. As he said, he had not a square inch free. He had, however on the trunk many small irregular patches which were free, and on this the skin was quite pale.

CANCER AND THE CANCEROUS PROCESS.

Polypoid Growths from the Nipple Areola.

In the January number of ARCHIVES for 1897 will be found a paper with the above heading, illustrated by several sketches. I claimed for these pedunculated outgrowths that they originate in the tubercles of Montgomery, and was fortunate to be able, in one of the sketches, to show their early stage. A case recorded by Mr. Birkett and another by Mr. Marmaduke Shield were mentioned. I now recur to the subject in order to mention the fact that the reader will find in the *Practitioner* for November, 1897, two other examples of this form of tumour recorded by Mr. Bland Sutton. One of these was recorded by Mr. Alexander Shaw in the third volume of the Pathological Transactions, and I regret that when I wrote my paper I overlooked it. The other is from the surgical practice of Mr. Henry at the Middlesex Hospital, who excised the growth in 1837. Both specimens are, I believe, preserved in the museum of that Hospital. Both are clearly examples of the affection with which my paper was concerned. In both, the statement that the tumour was congenital is recorded. Unless the evidence on this point was definite and detailed, I may confess to some doubt. In my cases the tendency to overgrowth began in adolescent periods, but in none was it really congenital. Montgomery's tubercles are of course present at birth, and may be larger in some individuals than in others; but it may be doubted whether their hypertrophy is ever obvious before the period of puberty.

One of Mr. Sutton's specimens is the subject of a wood-cut, which shows a long, slender peduncle. In one case

the woman was forty-four at the time of the operation. The age in the other is not given. It is stated that the tumours were "of fibro-cellular structure."

Papillomatosis and Cancer.

A clergyman of sixty-five consulted me on account of a papillary growth on his tongue. It was exactly in the middle of the posterior part (the usual position), where the tongue does not touch the palate. He had known of it several years, indeed he had shown it to me two years before, and I had given him chromic acid to paint it with. He had now in addition, on the hard palate, long symmetrical streaks of little florid budding points. I have seen just these appearances on the hard palate several times, and they are certainly an early stage of epithelioma;—a pre-cancerous stage. They are, however, often present several years before any actively malignant processes are initiated. They are a form of grouped papillomata. The growth on the tongue in this instance showed no tendency to assume cancerous changes, but consisted of a group of branching papillæ without thickening at their base, a quarter of an inch high, and without ulceration. The patient denied very emphatically that there was any history of cancer in his family. When I inquired whether he had himself in youth suffered from warts, he replied, "Oh yes! when I was a schoolboy my hands were covered with them."

Another patient seen the same day afforded strong confirmation of the belief that family proclivity to cancer and to papillomatosis go together. He consulted me on account of warts on the head. He was nearly bald, and his scalp was covered with papillomatosis growths in various stages. Most of them were quite low, but a few were fimbriated and of some height. This gentleman (æt. 58) had lost two sisters and an aunt from cancer of the breast. He had never in youth been the subject of warts, nor had he them now on other regions than his scalp.

A SOCIETY AND A COLLEGE.

IN the pages of my ARCHIVES, as a rule, no topics but those of clinical interest are dealt with. I am tempted, however, on the present occasion to deviate from this custom in order to say a few words in advocacy of two Institutions in the prosperity of which I am deeply interested. These are the New Sydenham Society and the Medical Graduates' College and Polyclinic. I will speak first of the

NEW SYDENHAM SOCIETY.

This society has long outlived its name, and is "new" only in contrast with its predecessor. It is now in its forty-first year, and its publications, averaging four a year, have reached a total of one hundred and sixty-seven. It is not, however, just now in quite such a prosperous condition as once it was, and in 1894, 1897, and 1898 it has been able to afford only three issues a year. It is in the fear that its members' list may yet further decline, and in, at the same time, a full belief that to prevent such a result, and to restore again its palmy days, nothing is needed but a correct appreciation of the facts by the profession at large, that I am induced to make the present appeal. The Library of the New Sydenham Society contains some of the most valuable medical treatises in any language. Had it not existed, the progress of medical knowledge in Britain and her Colonies would have been much slower. There is still much useful work before us, and it will be an event much to be regretted if its career be allowed, in any degree, to decline.

As the number of Original Members now surviving is not large, it may perhaps be of interest to many to record a few facts as to its beginnings. "The Sydenham Society," or,

as it is now sometimes termed, the Old Sydenham, had for about sixteen years pursued its course—but with gradually diminishing success, so far as its members' list was concerned—when in 1857 it was decided to wind it up. The reason for this was that its income no longer sufficed to permit the publication of a sufficient number of books to reward its subscribers. A public meeting of its members was called, at which its President, Sir John Forbes, presided, and which I, as one of its members, attended. At that time I was young and enthusiastic, and I spoke strongly against the proposed dissolution and in favour of the selection of more modern and more attractive books. Sir John met me roundly with the half-sarcastic suggestion, "We have done our best and are not inclined to go on with it. If you young men think you can do better, found a society for yourselves." On leaving the meeting, Dr. Sedgwick Saunders, whom I had not previously known, met me at the door and encouraged me to take Sir John's irony in earnest. I went to my friend, Dr. Bevill Peacock, and from him to Mr. John Hilton, Mr. Solly, and Dr. Quain. The first meeting was held in Dr. Peacock's dining-room, and was attended by those named and some others. Dr. C. J. B. Williams was asked to become our first president and Dr. Barlow our first treasurer. Our organisation was almost exactly that of our predecessor, but with a clear understanding that we were to aim at a more modern class of works, and more especially at those needing expensive pictorial illustration. Our success was soon established. Local secretaries (honorary) joined us readily, and soon sent up long lists of members. In our first year we issued five printed volumes, and in our second we commenced an Atlas of life-sized portraits of Skin Diseases and a Year-book. The former of these proved very attractive, and in 1873, chiefly, I believe, as a result of its regular annual publication, our income reached the total of three thousand four hundred and fourteen pounds (£3,414), probably the largest that any publishing society has ever attained, and one which we have never either before or since exceeded. The regular publication of the Atlas of

skin diseases ended with its fifteenth fasciculus in 1875, and in 1877 an Atlas of Illustrations of Pathology was commenced. The Year-book had always been very expensive, and although its departments were in the hands of some of the best men of the day (Dr. Grailly Hewitt, Mr. Hulke, Dr. George Harley, Dr. Hilton Fagge, and others), it had not been a great success, and after having been for some years reduced to a Biennial Retrospect it was in 1875 finally given up. One reason for its abandonment was, I well remember, that other similar enterprises—more especially the *Medical Record* in the energetic hands of Mr. Ernest Hart—had superseded it. It is needless to say that in view of the admirable *Résumés* of current literature now given in the *Lancet* and *British Medical Journal*, and more recently in the *Review of Reviews*, there is no need whatever that our Society should undertake work in this direction. In 1877, two years after our last Biennial Retrospect, the Society had the honour of publishing the first edition of Dr. Neale's "Medical Digest," a work which has since maintained an independent and most useful existence. In the following year, 1878, was commenced a most important undertaking, which is only just approaching completion, and which, during its twenty years of issue, has proved a source of much trouble and anxiety to the Council and of some dissatisfaction to our members. It is satisfactory to know, however, that respecting the "Lexicon of Medical Terms" no differences of opinion have ever been expressed as to its value, the only complaint having been as to the delay in its completion. Now that the work is at last finished, we hope that this source of regret will soon disappear. The reasons of the delay have been many and various. In more than one instance the Society has been deprived by death of the services of an editor who had made extensive preparations, but had completed but little; in others illness, and in others private engagements have had a like disastrous result. The work is, however, at last complete, and preparations for Appendices are well in hand.

I have alluded in what I have just written to some of the larger undertakings in which the Society has engaged.

It may be fairly claimed, however, that not a few of its other publications have been of first-rate importance, and that many of them are classics of permanent value. We began with Diday's short monograph on Congenital Syphilis, and have since issued in two volumes Lancereaux's general Treatise on Syphilis and Colles' works. In skin diseases we have given the five volumes of Hebra and Kaposi's work, and in addition many special clinical lectures. Trousseau's "Clinical Medicine" in five volumes, and Hirsch's "Handbook of Geographical and Historical Pathology" in three, are both of them works as valuable now as at the time of their publication. On the subject of Nervous Diseases we have published almost the whole of Charcot's writings and those of Pierre Marie; an epitomised edition of Duchenne's works, Griesinger on Mental Pathology; and numerous clinical lectures on special topics. Midwifery, Gynecology, and diseases of children have been liberally illustrated in the works of Henoeh, 2 vols.; Pozzi, 3 vols.; Spiegelberg, 2 vols.; Smellie (edited by McClintock), 3 vols.; and many selected essays. In 1880, when the subject was somewhat novel, we published Koch's researches on Wound Infection, and in 1886 Mr. Watson Cheyne edited for us a thick volume of Selected Essays on Micro-parasites in Disease, which was followed three years later by Flügge's Treatise on Micro-organisms. In view of the yearly increasing interest of the British Empire in diseases occurring chiefly in foreign parts, our subscribers have, during the last few years, had supplied to them the most recent information on Malarial Parasites, on Leprosy, and on Yaws.

I have said enough, I hope, to show that the Library of the New Sydenham Society is one of the highest practical value, and that it has been the aim of the Council to provide promptly the newest and best information.

So valuable has the New Sydenham Library been felt to be by some of those who possess it, that proposals have been made to the Council that an Index to it, as a whole, should be prepared. Although the books are of very various character, such an Index or Digest might be very useful were it not for the practical difficulties in its mode of formation.

As the Society is now in its forty-first year, it cannot be supposed that many of its members are original ones, and possess, in right of continued subscriptions, complete sets of its volumes. The issue has, however, been so large that its books now very frequently find their way into the second-hand market, and those wishful to complete their sets can usually do so without much trouble. The Council has also offered facilities to new members for obtaining back volumes at much cheapened rates, and these will probably be increased in the future.

There is one feature in the organisation of a publishing society such as ours to which I am desirous to secure attention. It is that success breeds success. The cost of a large edition of a book is not, when once the type is set up, much greater than that of a small one. Paper and binding are the main items of cost which the third and fourth thousands have to bear. This most especially applies to Illustrated Works and to Atlases of Plates. If, therefore, our Society could again realise its long *rôle* of subscribers it would be able again to give more books, and more costly ones, for each guinea subscription. This would increase satisfaction and bring new members. The policy, then, of any member who may feel disappointed at receiving only three works for his subscription instead of five, as in the prosperous days of the seventies, ought to be, instead of resigning and thus adding to the evil, to set himself to secure new members.

It is not necessary that I should give any details as to the conditions under which back volumes of the *Lexicon*, the *Atlas of Pathology*, &c., may be obtained. These particulars may be obtained at any time on application to the Society's agent, Mr. Lewis, in Gower Street.

As regards the Society's future, without pledging the Council to any policy, I believe that I may venture to indicate certain lines which will probably be followed. The *Lexicon* being now concluded, the income thus liberated will probably be devoted to the more frequent production of fasciculi of the *Atlas of Pathology*. It is further possible that the scope of this *Atlas* may be

widened, and made to include clinical illustrations from the living patient as well as visceral and histological subjects. It is recognised by the Council that the reprints of English works of merit and of collected editions of the writings of British medical men recently deceased has already been carried as far as is desirable. Works of this class will in future be avoided. On the other hand, the translation from foreign sources of clinical lectures and brief monographs in the form of "Selected Essays" is believed to have been very useful and well appreciated. It is intended to have a yearly volume of this kind. It is precisely this kind of literature which conveys the most recent information on the subjects treated of, and which at the same time is most difficult of access in our libraries and the most liable to be lost sight of. The translation also of larger works of sterling merit, more especially of those which, as being expensively illustrated, are unlikely to be reproduced by publishers, will also be continued. The times have, however, as regards these works, somewhat changed since the early days of the Society, the enterprise of the trade being now far greater than it then was.

If I may now turn to the practical aspect of the question as to how the future prosperity of the Society may best be helped, I will ask attention to several points. WE WANT MORE MEMBERS.

In the early days of the Society its prosperity depended to a very large extent upon the active exertions of the Honorary Local Secretaries, and its partial decline is to be explained by the fact that great changes in these officers have necessarily taken place. Fewer places are now represented than was formerly the case, and in some instances much less zeal is manifested than was shown in our early days. The three duties of a local secretary are to endeavour to enlist new members, to get in their subscriptions, and to distribute the books. The latter function has been much lightened by the improvements in the postal system which have been made since the Society was established. In many cases now it saves both trouble and expense to send the books direct from the office by post instead of through the local secretary. The other

two functions have, however, lost nothing of their importance, and it is much to be desired that the list of gentlemen in these appointments could be largely increased, and that the zeal of those in office could be stimulated. I cannot but think that a Society which has done so much for sound medical literature has some sort of claim on the support of those well-to-do members of our profession who have its best interests at heart. It may be that they have ceased themselves to read many books, and do not personally desire to accumulate more. Still it may be urged that the annual guinea for such an object need not be grudged, and that it will never be difficult to find amongst younger, and as yet less prosperous confrères, those who will gladly find room for the books, and make good use of them. There are also many public institutions which would gladly receive such donations. What I plead for is that our Society merits the liberal support of the wealthy part of the profession, irrespective of personal needs.

As regards the appointment of local secretaries, I may say that the Council is always willing to receive volunteer offers of service, and in reference to new members that there are no formalities of election whatever. All that is necessary is to make application and to send up a subscription.

The New Sydenham Society has had in its list of presidents most of the more distinguished members of the British profession during the last forty years. Its Council has always been an influential one and well representative of all branches. Its Council meetings have always been well attended, and much interest has been taken in its affairs. On only one occasion during the forty years has there been a failure to get a quorum.

The long-continued services of Dr. Sedgwick Saunders in the onerous office of Treasurer deserve most especial recognition.

THE MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.

In what I have written above as to the claims of the New Sydenham Society I trust that it will be clearly under-

stood that the statements put forward are made on my own responsibility and without any authorisation from the Council. I am especially desirous that this should be understood in what I am now about to write concerning another Institution which is as yet in its infancy.

The Medical Graduates' College and Polyclinic has been organised with somewhat complex but correlated aims. It designs in the first place to supply the wants in London of graduates in medicine from all parts of the world, and next to develop a new form of medical relief to the poor which shall consist in giving advice only. Respecting these two primary aims I do not purpose to say more than a few words, as they have been well explained in the College Journal and elsewhere, and are probably well understood. The one is to be secured by the organisation of teaching classes and lectures, and the other by daily opportunities for consultation under suitable restrictions. It is in reference to certain collateral developments of our scheme that I wish chiefly to speak. Not only will the Polyclinic be a teaching college and consultative out-patients hospital, but it is hoped that it will powerfully serve to promote the progress of clinical knowledge. Our consultants and teachers will be freed entirely from the necessity of reiterating preliminary matters, and will always have before them as auditors those who are already well informed in essentials and quite prepared to discuss moot and difficult points. This fact will constitute a most efficient incentive to zeal and industry in the investigation of new facts. For such investigation the machinery of the Institution will afford every advantage. There will be a well-fitted laboratory, microscopes, chemical tests, the Röntgen rays, a large collection of portraits, atlases, &c., always at hand, and plenty of help to be had in their use. It is hoped that the plan of consultations will bring to the Institution many examples of rare forms of disease. Efforts will be made to collect such in grouped series from hospitals, workhouse infirmaries, and private practice, and a special fund will be provided to assist patients residing at a distance whose attendance is desired, either for their own good or for clinical demonstration, to come up to town. At these

specially arranged consultations the attendance as consultants of those most skilled will be invited. Thus it is hoped to arrange a sort of Clinical Society on a large scale and with daily meetings, and to obtain rapidly an accumulation of material which will be most valuable. Nothing so surely conduces to the correct appreciation of a rare malady as placing side by side several examples of it in living patients, and with them all the published portraits which can be collected. Careful records of these clinical demonstrations will be kept, and will from time to time be published in the College Journal.

Another department of clinical observation from which good results may be expected is the appointment of standing committees for the collection of evidence on special subjects. Those already appointed undertake Leprosy, Tuberculosis, Yaws, and the Geographical Distribution of Disease. It is proposed that such committees shall in the first place endeavour to secure for the library and museum all important reports or pictorial illustrations which may be published concerning them. Their duties, however, are not to end here. They are to invite manuscript or even *vivâ voce* communications from all who have special knowledge concerning it. It is hoped that most colonial and foreign medical men visiting London will find their way to the Polyclinic, and that from many of these valuable first-hand information may be obtained. It will be the aim of these committees to secure interviews with observers of this class, and to place on record the information given. Lists of questions will also be prepared to be answered by those resident abroad and enjoying opportunities for special observation, and it is possible that foreign correspondents may be appointed. I can conceive it quite possible that permanent committees of this institution may in the course of a few years, by the quiet collection of evidence and examination of witnesses, set at rest some of the important questions still in debate as to such diseases as Leprosy and Yaws.

I have already said that I think that all medical men to whom a guinea a year is of no great moment ought to join

the New Sydenham Society and thus aid in the production and diffusion of medical literature, and I will now add that those who can spare two guineas will do well to encourage clinical observation by subscribing to the Polyclinic. For the present any medical man whose name is in the Directory can for one guinea become a member, and by doing so will not only assist a good work, but secure certain definite privileges for himself. He will be able to at any time attend the consultations, and may bring any of his poorer patients for advice; he will also have access at all times to the reading-room and open library, and will be entitled to receive the Journal.* These advantages will, I trust, prove attractive not only to those resident in or near London, but to many provincial practitioners to whom the yearly increasing railway facilities afford opportunities for frequent visits to the metropolis.

* Any medical man wishing for a copy of the first issue of the Polyclinic Journal can obtain it by writing to Dr. Hawthorn at 22, Chenies Street, and enclosing a penny stamp.

ARCHIVES OF SURGERY.

JULY, 1899.

A CLINICAL STUDY OF DISEASES OF THE NAILS.

(Continued from page 159.)

IN continuation of my Clinical Report of Diseases of the Nails, I now proceed to adduce examples of that form which occurs in connection with *Common Psoriasis* of the skin. The most typical form of this is, I believe, primarily an affection of the nail-bed. It usually begins by loosening of the nail from its attachments to its bed at its free edge and sides. An accumulation of dry epidermis mixed with particles of dirt takes place between the nail and its bed, which causes the nail to look discoloured and dead. In many cases, however, the nail itself is not altered, and remains transparent. The circumstance of its being loose from its bed, however, soon leads to defects in its nutrition, and it becomes more or less opaque, fibrous, and brittle. In some extreme instances it breaks away from its free edge backwards, until only a small portion remains sound and smooth and bright on its surface.

During the process of loosening of the nail from its bed the breaking up of its substance may vary much in different cases. In rare instances almost the whole nail becomes loose, and in some it is even exfoliated entire. More usually, however, breaking up into fragments sets in early.

Although I believe that the process above described is the one most usual in patients who are the subjects of psoriasis, and that it should be designated as Psoriasis of the Nail-bed rather than as a disease of the nail, yet it is to be admitted that a great many cases are complicated. This arises, it may be suggested, from the fact that the type of psoriasis of the skin is itself liable to various modifications. It is often not possible to distinguish between a nummular dry eczema and psoriasis, and many forms of what is called eczema are cognate in cause with psoriasis. To find the type of psoriasis-nail-disease, we must take only cases in which the patient is actually the subject of characteristic and unmixed psoriasis of the skin. Such cases are not very numerous, but it is from the examination of some such that I have arrived at the opinions just expressed. Much larger groups of cases are made up of those in which the skin shows only few patches, and these it may be ill-marked, of those in which there is no skin-disease in the patient, but psoriasis in a near relative; and lastly of those in which no proof can be obtained of tendency to skin-disease in either the patient or his relatives. If, however, in these three groups the type of psoriasis of the nail-bed is well maintained, we have, I think, fair grounds for assuming that the cause, or proclivity, is the same.

A very large majority of psoriasis patients escape nail affections altogether, and there is nothing improbable in the converse proposition that many of the subjects of psoriasis of the nail-bed escape the affection of the skin.

If the type of the skin-disease be mixed, if, that is to say, there be difficulty in deciding whether it should be called dry eczema or psoriasis, then the type of nail-affection will be mixed also. In eczema the surface of the nail, rather than the nail-bed, suffers, and the evidences of disease are usually first seen near the root and not at its free edge. In a large number, perhaps a large majority, of examples of chronic nail-disease these conditions are present in a mixed form.

Psoriasis of the nail-bed is by no means always a slight affair or a mere disfigurement. It often is attended by much aching in the finger-ends, and sometimes by swelling

and much inflammation. Its onset is occasionally sudden and its course almost acute. Its most severe forms are, I think, met with in elderly persons.

In the following citation of cases, I shall endeavour to take first those in which the evidence as to connection with psoriasis is the most definite. One item of proof of this will be found in the amenability of the nail-disease to the influence of arsenic. Possibly almost all cases of chronic or relapsing nail-disease occurring in persons in good health, arranged with symmetry, influenced for good by arsenic, and not attended by precedent skin-disease, should be counted as of a psoriasis nature. If this proposition be adopted, we shall find considerable variety as to the conditions assumed by the nails themselves, but in the main what I have written above will be borne out.

CASES ILLUSTRATING PSORIASIS OF THE NAIL-BED.

Psoriasis of the Nail-bed with indications of Psoriasis on Elbows—Notes on the influence of Arsenic.

Mr. W——, a married man, aged 28, a solicitor, from C——, came to me on July 24, 1893, suffering from disease of the nails of three years' duration. It had begun on the middle finger of the right hand; the thumbs were most severely affected, but the little and ring fingers, on both hands, had entirely escaped. The disease began in the right foot about a year previously, but the left foot was not involved at all. The nails were undermined at their sides and borders, and there were accumulations of epidermis under them. On the elbows were some dry, rough patches, which, however, scarcely amounted to psoriasis. There was no skin-disease elsewhere, but the cheeks became rough on exposure to east wind, and little rough patches appeared on the ulnar borders of the fingers and on the backs of the hands. On the shoulders there was some acne. Mr. W——'s mother had what had been called "dry eczema." There was no history of syphilis. In January, 1894, I found that the effect of the arsenic, which I had advised, had been to nearly cure his fingers; so that they

were quite comfortable, and he could again hold a pen. The nails at their ends, however, showed a tendency to break into fibres. The toes, on the contrary, were no better; and the great toe-nail of the left foot was just becoming involved, an opaque patch having formed under the free edge at one side. He had taken arsenic from July to Christmas, and then discontinued it, as his feet were so swollen that he could hardly get his boots on. The dose had been nine minims of Fowler's solution three times a day. After a fortnight, however, he began it again in smaller doses. At the time that the full doses were taken, the eyes had become red.

I did not see Mr. W—— again until November 26, 1898, when he gave me some very interesting facts. Under the influence of arsenic pushed to doses of eight to nine minims three times a day he had, he said, often got his nails almost well. He had, however, repeatedly been obliged to leave off the drug as it made his eyes hot and the soles of his feet tender. On leaving it off his nails always relapsed, but they had never been so bad as they formerly were. He had maintained good health, and was florid and robust, though he had been taking stimulants too freely.

The type of nail-disease was still what it had been, that is loosening of the nail from its bed and accumulation of epidermis between them. The little and ring fingers of both hands had still maintained their exemption.

Psoriasis of Nail-bed in association with Patches on the Skin.

In the case of a Mr. F——, aged 31, who was brought to me by Dr. Fred. Mackenzie on September 1, 1880, the typical condition of psoriasis of the nails was present and was almost symmetrical.

The condition was coincident with a large dry scaly patch on the scalp. Nearly two years later I saw the same patient again. Some of his nails had got well, but others had been attacked. The conditions were still those of psoriasis, and the patch on the scalp, which had been for a time almost

well, had again relapsed. There was a possibility of specific disease, but I do not think that it was probable.

Psoriasis of Nail-bed with Psoriasis on Skin.

George V——, aged 43, from Nottingham, consulted me in March, 1893, at which date the following notes were taken:—

He has suffered from boyhood from psoriasis on his body; it is now quite well and has been so for three years. It was called "psoriasis" by those who saw it, and he was treated with arsenic. He thinks that he has suffered from his nails for six years; but worse during the last four. The state of his nails very often prevents him from following his occupation (since some nails become painful), in which, as an upholsterer, he needs the ends of his fingers. Although the psoriasis has quite left his body he has a large persistent patch on the front of one leg, which for the last two years has never left him. It is abruptly margined, and covered with dry furfuraceous scales more like a dry eczema than a common psoriasis. He appears to be the subject of a congenitally dry skin. He does not know of any hereditary skin-disease. At present the nails of his left thumb, forefinger and middle finger are affected, and all present a characteristic condition of psoriasis, having become loose at their edges and sides, and opaque in their structure where loose. The other parts of these nails and the other nails are smooth and polished. The affected nails are not in the least fibrous or thickened, but remain quite polished on the surface even where loose. They are very tender to pressure. He complains a good deal of aching in the fingers, "in the bones." He is the subject of a rosaceous acne on the face. I must add to this description, that although at present the nails are not in the least affected, except at the edges, the patient asserts that sometimes the disease begins as a red spot under the nail near to the lunula; looking, as he says, "like a bruise." When the disease begins in this position it gradually extends forwards.

On May 30 of the same year he had had another outbreak of psoriasis on his legs since I had prescribed for him, and it was still present. His nails were almost well, but he said they had often got better and then relapsed. He complained much of pain in the finger-ends and in the bones of fingers.

I had given antimony, and used chrysophanic acid. His too free use of spirits had probably much hindered the cure.

A type-example of true Psoriasis of the Nail-bed (Nail-disease in association with true Psoriasis of the Body).

I cannot narrate a more typical example of true psoriasis of the nails than that presented by a young gentleman named A——, whom I saw in October, 1890. He was 26 years of age, and had never had any form of venereal disease. His mother was the subject of psoriasis in a mild form, and her nails had also suffered slightly. The affection of Mr. A——'s nails began when he was a boy of eleven, and was for several years confined to his left ring finger. Then it spread to the other fingers, and more recently to those of the other hand. At the age of eighteen he became liable to psoriasis patches in the skin of the limbs and trunk in the usual positions. The patches were quite characteristic, but somewhat less scaly than usual. He was under the impression that hot weather made his skin better and his nails worse. He had lived both in India and Russia. In the latter place he expected his nails to become much better and in the former worse, and *vice versa*. When Mr. A—— came to me all his finger nails were severely affected with the exception of the index finger of both hands, which remained perfectly sound. His nails were originally very good ones, smooth, hard and well formed. The psoriasis had affected them in the usual way by loosening them from their beds, at their sides and ends. This loosening was attended by a dirty-looking opacity of the nail substance, and in some instances it extended more than half-way down the nail. Some of the nails were a little pitted and eroded on their surfaces, but for the most part they were quite smooth and hard, the disease being chiefly the loosening which had been described. Mr. A—— thought that his hair was getting thin, and he had several patches of psoriasis on his scalp. He said he could not take arsenic, that it "poisoned" him without doing good. In spite of this statement I prescribed it for him, giving doses of m. viii of Pearson's solution, combined with ʒi of the bichloride of mercury. He took this mixture and used a chrysophanic acid ointment for about five weeks, with the result that both the nails and

the skin were well. I allowed him to diminish the dose of the medicine, which he said caused him weight at the pit of the stomach all the time he was taking it. Soon after his second visit to me he went to the Bermudas, and there left off the medicine or took it with great irregularity. He returned nine months later with the nails as bad as ever, and with a mild return of the psoriasis on the skin. He said that he could always keep the skin in check by using my chrysophanic acid ointment, but added that it had no effect on the nails. I begged him to persevere with the arsenic in full doses, and prescribed it for him in the form of Pearson's and Fowler's solutions. A fortnight later I still further increased this dose, giving him the usual cautions as to its use.

The following fragmentary notes record the progress of the case :—

January 26, 1892.—Nearly well. He finds the arsenic do his nails good, but it causes weight at pit of stomach, a distressing and depressing feeling. He is sure that the addition of Liq. Hydr. Bichl. much increases the efficacy of the arsenic. He has got quite rid of pains at his heart by giving up smoking.

April 20.—In spite of arsenic he has had a relapse. Is taking four minims of Pearson's with six of Fowler's solution. He thinks that the fortnight of hot weather in beginning of April made his nails worse.

He shows me some isolated *brown patches under the nails at a distance from their edges*. They are seen through the transparent nail, and look like a speck of decay in an apple rind.

His skin remains quite well. His health is good. He never before had the nails relapse whilst taking arsenic.

June 29.—He has taken no arsenic for three weeks. He left it off because his eyes were sore. He had no other disagreement. His nails are all but well; with one or two slight exceptions they are all smooth and hard.

I have no further notes of the case.

Psoriasis of Nail-bed, with Psoriasis of the Skin.

Mr. K——, a married man, aged 32, came to me in July, 1883. The finger-nails were affected symmetrically, but until just lately the ring fingers had escaped. The disease always began either at one side or at their free edges, and spread down towards the root, the portion affected becoming shrivelled, and opaque. Ultimately the nails became

withered and thin, depressed in their middles and loose at the edges. The disease of the nails had lasted on and off for three years, having begun after medicine had been taken for scaliness of the scalp. There had never been characteristic psoriasis on the elbows or knees, and on the body there was only a single patch on the left side of the chest. At one time, however, (I was told) there had been many patches on the body.

Psoriasis of the Nail-bed in association with Psoriasis of the Skin.

Mr. F. W. B——, aged 35, offered an example of nail disease in actual association with psoriasis. He stated that his father, his grandfather, a paternal uncle, and one of his brothers, had, like himself, suffered from psoriasis. His own history was, that once, seven years ago, he had been very severely chilled out hunting. His expression was that he “could not get warm for three years afterwards.” He said that very soon after this event some dry patches appeared between his fingers. During succeeding years psoriasis developed over almost his whole body, trunk, limbs, and face. The patches were very large, and having become confluent, were almost universal. His nails had, he thought, been affected, when he came to me, only for two years. Many of them had been repeatedly shed, and all the nails, both of fingers and toes, had been affected. He considered that he was better in warm weather, and always expected a relapse in spring and autumn.

The affection of the nails was usually an undermining, beginning at their tips, but sometimes would begin at the sides or even at the root. I have no record of the results of treatment.

Psoriasis of the Nail-bed of all the Fingers and Toes.—Ten years' duration—No Skin-disease—History of the same malady in three generations—Note as to the state eight years later.

A gentleman named G——, aged 39, who had lived in China, consulted me on January 26, 1884, on account of a

very typical condition of psoriasis of the nails, wholly without skin-disease. All the nails of all his fingers and toes were affected, and the symmetry, as regards degree of severity in different digits, was most exact. In all the condition was that of loosening of the nail from its bed, and grey opacity of the portion so separated. The structure of the nails was in other respects but little altered. When it extended by the side of the nail the latter became a little corrugated, but not when the end only was involved.

Mr. G—— had no other skin-disease and was in excellent health. His nails had been more or less diseased for ten years. He stated that his father, æt. 70, was the subject of diseased nails, and that one of his children æt. 8, showed a tendency to it. Neither his father nor his child had any skin-disease. He was somewhat dyspeptic, and the only influence concerning which he felt sure that it made his nails worse was that of free living. If he dined out and took champagne his finger-ends always became hot, and fresh invasions of disease showed themselves; otherwise they gave him but little trouble.

I saw Mr. G—— again in 1892, eight years after the above notes. He had not followed up the arsenical treatment which I had prescribed, and his nails were much in the same condition as above described. They were not worse, and he was still quite free from skin-disease. On this second occasion he came on account of a papillary patch inside one cheek threatening cancer. He had abandoned all treatment for his nails.

Recurring Nail-disease in association with Psoriasis of Skin.

Mr. J. W. D. J——, a middle-aged man, consulted me on the 25th of June, 1879, for psoriasis of the finger- and toe-nails. My notes do not describe their precise condition. He said that he had had four attacks, one every summer, and that his nails were usually better in winter. A single patch of psoriasis, his first, was just making its appearance on one knee. He was in good health, but liable to bilious attacks.

A subsequent note, taken July 28, 1880, states that Mr. J—— was then suffering from a relapse of his nail-affection in the fingers and toes; otherwise he was in good health. The nails were loosening at their edges. He repeated his statement that he was always better in winter, and that in summer his nails were always worse.

Disease of Nails following a peculiar form of Papillary Psoriasis.

Mr. B——, whose case is recorded in ARCHIVES, Vol. I., p. 376, was under my care again in 1893. He was then 83 years old, and he was still in excellent health, but much troubled by chronic disease of some of his nails and the skin of his legs. The nails had become thick, opaque, and fibrous. The thumbs suffered most severely, and next the forefingers. The characters were partly those of psoriasis and partly those of eczema, *i.e.*, some of the nails were affected at their roots and others at their free borders. He had had crusted patches on the cleft of the nates and in the cleft between the left thumb and forefinger. During the six months following the dates to which the above notes refer (Sept. 6, 1893), Mr. B—— had a very troublesome eruption on his feet and lower part of legs. It much resembled that which he had suffered from five years ago, being a sort of papillary psoriasis. Thick, crusted, dry patches formed on the sole and dorsal surface of the feet, between the toes, &c., which for a time almost disabled him from walking. Under treatment by frequent painting with creasote, tar, &c., and the use of Martin's bandages, he got almost well; but the cure was very tedious.

The following notes continue the case :—

May 12, 1892.—He is better everywhere. The accumulated epidermis under his nails is horny, and adheres very firmly to thickened papillary structure of the nail-beds. It is literally as hard as horn. It is under toe-nails as well as others. He has many hard lichenoid spots scattered over thighs and in popliteal spaces. He is taking Liq. Opii Sedat. m. vij, Liq. Sodæ Arsen., using creasote and a mercurial ointment. The palms are better.

On January 20, 1887, I ordered for him a dose containing ten minims of Battley's solution and one drop of Pearson's three times a

day. He was also to use a weak tar wash. On March 17, after his visit to me, I wrote to his surgeon: "Our patient is progressing much faster than I had dared to hope. My opinion is that the opium in the mixture is the most important agent in the cure. A few spots above his elbow, which have had no local treatment, have gone away. He may use the creasote less frequently as the patches get better, and may, after a while, sleep without his bandage."

On a subsequent occasion (no date):—His foot is almost well. He has left off his medicine. The indiarubber bandage and the tar and lead wash (strong) have been the chief agents in the cure. His nails are replaced by hard papillary growths.

*Psoriasis of the Nail-bed—A type case—Two attacks
with interval of twenty years.*

Mr. L——, 47, a gentleman in excellent health, presented a typical example of true psoriasis of the nail-bed. The present affection of his nails dates back about six months. Before that his nails had been sound, but with a little tendency to get loose at their edges occasionally. He had, however, five-and-twenty years ago, had a quite similar affection, which was protracted over several years in spite of treatment. His middle fingers escaped and one little finger, but with very fair bilateral symmetry, all the other nails suffered. One great toe-nail (the right) is affected, but none other. All the affected nails are loosened from their beds, so that a fine probe can be passed under them for varying distances; in some almost to the lunula. The nails retain their transparency and the probe can be seen through them. Owing to the collection of dirty grey epidermis under them they look opaque. There is not the least roughness of their surfaces, nor any congestion of the skin surrounding them. Their roots are quite healthy. There has been little or no pain in connection with the affection. He has experienced, however, a little heat and pricking, and in one this was so much that he feared the nail would "fester." The nails are naturally rather thin. He brings me Sir Erasmus Wilson's prescriptions, dated July 16, 1872. He was under Wilson several years. A strong solution of chloride of zinc was ordered to be brushed under the nails, ʒss ad. ʒss, then ʒss ad. ʒss, then equal parts. Arsenic in steel wine was given, and was continued in increasing doses for several

years. On that occasion, as in the present, one toe-nail began to suffer long after the fingers. This toe-nail, the right, never got quite well, and is now again extensively undermined.

As regards the treatment on the former occasion, he is under the impression that the chloride of zinc application did not do much, and that it was the arsenic which effected the cure. He was under treatment several years and took arsenic almost all the time. On that occasion he lost several nails, and had mere stumps for some time. Eventually they grew quite well again, but always showed some tendency to become loose at the edges. For twenty years, however, he had no material trouble with them. The right great toe-nail was the one in which chiefly the disease persisted.

There was a history of gout in the family and also of cancer, but not, so far as the patient knew of, any skin-disease. He himself had never had patches on the skin. I examined his elbow-tips for psoriasis, and found none.

*Severe Psoriasis of the Nails of fifteen months' duration—
Complete cure by a four months' course of Arsenic—No
disease of the skin and no known inheritance.*

Mr. W——, April 29, 1897.

*Severe Disease of the Nails, resembling the changes of
Psoriasis, but without any concomitant skin-disease—
Both toes and fingers affected—Nails becoming opaque
and loosening at their edges.*

Mr. Sidney R. P——, aged 40, August 26, 1890.

Acute Psoriasis of the Nail-bed in an old woman.

A most unusual example of acute inflammation of the nails in an old lady was sent to me by Dr. Hearndon, of Sutton, in October, 1898. She came with both feet wrapped up in cotton wool, and some of her fingers also. The ends of most of her digits were swollen and dusky, and some of them had lost their nails and showed pus crusts. At first sight I thought it was an instance of Raynaud's malady, if

PLATE CLXVI.

SEVERE PSORIASIS OF NAIL-BED IN SENILITY.

THIS Plate shows the condition of the nails in Dr. Hearnden's patient (see text, p. 205). The case was one of very severe psoriasis of the nail-bed in a senile patient. All the digits of both hands and feet were affected. The early stage of the disease was a loosening of the nail at its free border; but at a later period the nails were uplifted and exfoliated. Finally the whole end of the digit became involved in inflammation. The disease was, however, from beginning to end one of the nail-bed. The reason for calling the disease psoriasis is, that although in this instance the patient had no skin disease, a precisely similar affection has in other instances been met with in association with true psoriasis.

TABLE CLXVI.

WORDS OF NOTE IN SENTENCE



The following is a description of the nail in Dr. H. A. A. The case was one of very severe psoriasis. The patient had the digits of both hands affected. The early stage of the disease was a loss of the nail, but later; but at a later period the nail was replaced by a new one. Finally the whole end of the finger became involved. The disease was, however, treated by the use of the following remedy. The reason for calling the disease psoriasis is that in this instance the patient had no other disease, and the affection had in other instances been found with psoriasis and with true psoriasis.

not of senile gangrene. The feet were swollen and œdematous. More careful examination revealed the fact that the morbid process really centred in the nails or rather in the nail-beds, and that different nails showed it in all stages of its progress. The hands had been affected later than the feet, and on many of the fingers the onychitis was only just beginning. The patient stated that the first symptom was a pricking and stinging in the finger-end under the nail. Next, dusky red or brownish patches were seen under the nail at its sides or free edge. These gradually spread, and the nail became loose and was lifted by the accumulation of epidermis under it. In this the process exactly resembled what is usual in true psoriasis of the nails, but it was much more acute and rapid than is common in that affection. The accumulations under the nail consisted in part of moist secretion as well as of epidermic scales, and the nails in the course of a fortnight were loosened to their roots. Several of them had been shed and others were quite loose. There had been no great pain, and the patient had throughout slept well both night and day. The bed from which a nail had fallen soon became covered with a dry crust.

The subject of this remarkable condition was an old lady of 75, pale and rather stout, but not out of health. Her pulse was good, and the arteries could be felt even up the sides of the fingers. It was clear that there was no arterial obstruction. She asserted that she had, with the exception of rheumatism, enjoyed good health until about a month ago, and been able to take exercise and use her fingers. One of her middle toes was the first to suffer, and the others soon followed.

Having noted the identity of the process with that of psoriasis of the nail-bed, I inquired whether she had any skin-disease. She assured me that she had not, but added that in middle life she had been for some time under the treatment of the late Mr. Startin for a scaly eruption on various parts. It had, however, been completely cured, and had never relapsed. She believed that one or two of her relatives had some form of skin-disease.

This case is illustrated in Plate CLXVI.

The date of my first seeing Mrs. — was October 17, 1898. On December 10th I was asked to visit her at her home as she was unable to leave her room. I had prescribed a mixture containing three minims of Battley's solution of opium and two of Fowler's solution, and had advised that the nails should be painted twice a day with an undiluted solution of lead and opium. These measures had been carried out, but latterly the opium had been omitted on account of constipation.

It could not be said that any definite advantage had been obtained, other than that the pain and inflammation were less and that all suppuration had ceased. All the nails of her toes had come off, and their beds were occupied by dry crusts stained black by the tar. Her finger-nails still remained attached, but they could scarcely be recognised on account of the crusts. The ends of all the digits were enlarged, and the skin all round the nail was involved, presenting a dry, cracked condition. In some cases, especially on the great toes, a dry scaling dermatitis extended upwards some distance from the nail. There was no other form of skin-disease excepting dry scaly papules on the back of each foot near to the roots of the toes. Mrs. — had suffered from rheumatic gout for some years, and her left wrist had for long been stiffened and somewhat swollen. Since her nails had been inflamed many of the joints of her fingers had been involved in arthritis and were now swollen and tender. In both hands the ring and little fingers had become bent towards the palm and could not be straightened. Her arterial system was in a remarkable condition of hypertrophic dilatation, especially in her upper extremities. Her pulse was very large; the radial was felt on the slightest touch between the metacarpals, and the digital arteries were so large that the pulse could be counted on the sides of the second phalanges as easily as in many persons it may be felt at the wrist. The temporal arteries could not be seen, and could only with difficulty be found. The posterior tibials could not easily be found, but the anterior ones were certainly larger than usual and their pulsations were visible.

In general health Mrs. — had not materially failed, but

she said that her appetite was very poor. I had forbidden beer and wine and confined her to whisky and brandy, of which she was very tired. She had usually slept fairly well. No tendency to gangrene or ulceration had shown itself anywhere, and the inflammatory œdema which had been present in the first instance had quite passed away. Her father, I was told, had suffered severely from true gout.

At this second consultation we agreed to again allow port wine in moderate quantities. Instead of the arsenic, I prescribed tartarised antimony in doses of a sixteenth of a grain, with a grain of quinine in pill. As local treatment, the crusts and dead nails were to be removed by soaking in warm water, and then liquor arsenicalis to be painted on the exposed part. Alternative applications were also suggested, of chinosol and a water dressing of tar.

Psoriasis of the Nail-bed (fingers and toes) following an attack of Gout in an elderly woman.

Mrs. N——, æt. 58, a stout, gouty lady, was sent to me by Dr. Lee, of Chelsea. She had psoriasis of all her nails, both of fingers and toes. They were undermined, broken, and opaque. She had not had psoriasis nor eczema, but now had large patches of red erythema under her breasts. Dr. Lee, who sent the patient, wrote to me that the first affection of the nails had followed an attack of gout in one foot. Some of the nails had fallen off, but new ones had been produced. Iodide of potassium, colchicum, and ichthyol had been used without any obvious benefit. I prescribed arsenic and a careful diet, but do not know the result. I saw the patient but once.

Some years later Dr. Lee was kind enough to try to procure information as to the sequel, but failed.

This case should be considered in connection with the preceding, and both of them are illustrated by the one which is to follow. All are examples of severe and general nail-disease occurring suddenly in women past middle age and assuming the type of psoriasis of the nail-bed. In two

there was much congestion and some swelling of the whole end of the affected digit. In two of the three cases there was but little proof of tendency to skin-disease, but in the third this link of evidence was conclusively supplied.

Severe Psoriasis of the Nail-bed affecting both hands and feet—Patient a middle-aged woman who had for long been the subject of common Psoriasis.

Amongst the patients sent to my consultation-room at the Polyclinic in May, 1899, was a stout woman, aged about 50, who had severe disease of the ends of her fingers and toes. These were swollen and reddened, and the toes were so painful that she could scarcely walk. Plate CLXVI. illustrates the state of things, though in a much exaggerated degree of severity. On examination it became evident that the affection was in the main one of the bed of the nail, all the rest being simply involvement from contiguity. The nails were uplifted by epidermic accumulations, and some of them were almost detached.

The history given was that the nails had been involved only for about six months, and were getting worse, but the patient added that she had been the subject of skin-disease for many years. She showed us large patches of common psoriasis in a most typical condition on the fronts of her legs and on the elbows. The patches were not numerous, but some of them were very large and all were quite dry. These patches had given her little or no trouble, and she had not sought advice until the nails became affected. She was in good general health.

(This patient was under the care of Dr. Guthrie Rankin, at the Waterloo Road Dispensary, to whom I was indebted for the opportunity of examining the case.)

Loosening of the Nail from its bed of the Psoriasis type, but affecting one finger only.

Miss M——, a very healthy young lady of 22, came on February 2, 1898, to show me her finger-nail. Only the left ring finger was affected, and she had no trace of any skin-

disease. The nail of the finger referred to was quite loose from its bed for two-thirds of its length, and where so loose it looked opaque and dead. A small probe could easily be passed under it, and without causing any pain. The finger was not inflamed, but just a little congested, and having its skin over the root of the affected nail a little glossy. Miss M—— told me that her nail had been in its present condition for three years, and she could assign no cause for its commencement. She was not aware that she had ever injured it. She said that frequently white specks would form in the nail and travel forward with its growth.

The condition here described is exactly that which sometimes attends psoriasis of the skin. I have never before seen it affecting one finger only.

Study of the conditions in Psoriasis of the Nail-bed—Patient a gouty adult—Psoriasis of Glans Penis.

An important opportunity for studying the conditions attending psoriasis of the nails occurred in the case of Mr. F——. He was an intelligent observer and had carefully noted his symptoms.

His nails had suffered for several years, their condition varying, being, however, but seldom that of health. They were liable to become loose at their sides and borders, and to have at these parts a dirty-grey epidermis accumulate between the nail and its bed. (This is what I regard as the condition characteristic of psoriasis.) Little or no change occurred on their surfaces, but where the loosening had been effected there the nail looked grey and dirty underneath. Almost all the finger-nails were more or less affected, and I was told that those of the toes were in a similar state. Dr. E—— drew my attention to the early stage of the affection, which consisted in the appearance of dark spots under the nail and visible through its transparent substance. Of these he showed me a great many, most of them of irregular shape and tending to coalesce. They were, he said, somewhat tender, and when they reached a certain stage he felt compelled to thrust the point of a penknife under the nail and liberate some grey stuff which had accumulated. When

this had been done the patch was added to the portion which had been previously loose, and thus the disease extended. Although the discoloration was a condition not very easy to represent pictorially, yet I did not like to lose the opportunity of procuring a drawing as my patient was willing to sit. Miss Green accordingly made a sketch of the two forefingers which shows what I have described fairly well.

Although Mr. F——'s nails were what I should consider typical examples of psoriasis, yet I must admit that he was not the subject of that eruption in its most characteristic form. He had come to consult me on account of dusky smooth papules on his glans penis, a condition which I have often recognised as psoriasis, and he had also some dry scaly patches in his ears. He had, further, moist eczema in the cleft of nates, between scrotum and thigh, and about the anus. The latter were attended by intolerable itching. He was a married man of about 40, in good health, but liable to gout. He had never had syphilis.

Psoriasis of the Nail-bed.

Father H——, aged 52, presented a characteristic example of psoriasis of nails. Sketch kept at College of Surgeons. (I have mislaid my notes of his case.)

Psoriasis of Nails with Psoriasis of Skin.

The following fragmentary note refers to a case observed many years ago, which I do not like wholly to omit.

February 9, 1887.—Mr. James P. W——, unmarried, aged 45. Usually in good health. Under Sir Erasmus Wilson all his life for psoriasis. Always worse in spring and autumn and then nails attacked. "Nails become like horn." It began in early life. No history of psoriasis in family.

Case of General Chronic Onychitis in an elderly woman in connection with Psoriasis and other forms of skin-disease.

March 26, 1878.—Mrs. E——, aged 60, has all her finger nails affected. They are but little thickened and there is no deposit under them. All the nails are alike, they split and

break up at their ends and all the free part is broken away. Longitudinal fissures run down the nails, but there are no pits nor any transverse markings.

The facts which connect this case with the dartrous diathesis are definite. One of her brothers has all his life suffered from a troublesome skin-disease "dry and scaly," and two other near relatives also are affected. She herself has eczema patches on the hands, and although she denied that she had anything on her elbows or knees, yet when we examined these parts we found dry patches of definite character, though not typical psoriasis. Ten years ago she had an eruption on her arms. She is chiefly engaged in washing, and her occupation may have modified the onychitis. On the toes there is much deposit under the nails (exactly like Mrs. R——). The finger nails give her no trouble excepting by breaking when she catches them against anything.

Disease of Nails in association with mixed form of skin-disease—Cure by Arsenic.

The case of Lady H—— is valuable as an example of nail-disease in association with eczema and gout, and also because it proves in the most definite manner the value of arsenic. Lady H—— was in the first instance sent to me by Sir William Roberts in 1887, and has been occasionally under my observation ever since. She was, when I first saw her, thirty-seven years of age, and is now forty-eight. She has a remarkably delicate and transparent skin, and had always, until the attack to be described, "beautiful" nails. They were, however, always rather thin. The type of disease, an inflammation of the surface of the nail beginning at the root and causing the surface of the nail from the root onwards to become pitted, fibrous, and discoloured. There was never any material implication of skin surrounding the nail, but on one occasion Lady H—— had a severe attack of eczema of the genitals, and several times had threatening of eczema on the neck. The eczema was always promptly cured by tar. The nail first affected was that of the right index, but subsequently all were involved excepting the ring and little

fingers. The ring finger escaped in both hands, but the little finger suffered in the left. The nail of one great toe suffered.

The nail-disease had been present six months when I first saw Lady H——, and she was greatly distressed about it, as it caused great disfigurement and she was much in society. She was at the time a widow. She had had more than one attack of gout, and stated that she could not take either quinine or iron without disagreeable tightness in the head and headache.

I prescribed arsenic in moderate doses, and it was subsequently pushed until her complexion was somewhat moody, and she lost her usual brilliance of the eyes. The dose was then reduced, her nails being almost well. During the first year of treatment it required much management to keep the nails moderately well.

The last time that I saw Lady H—— was in March, 1899. Her nails had been for some years practically well, and were now quite smooth. She had, however, continued to take arsenic, and said that if she left it off her nails always, after two or three months, began to suffer again, becoming pitted and fibrous at their roots. Her eczema had remained quite well, and her complexion was clear and skin quite free from eruptions. The dose of arsenic which she had of late taken was three minims of Pearson's solution three times a day, and this she thought she had usually taken six months out of every year, that is with intervals of two or three months at a time. There was no proof of any ill influence from the arsenic, and she said that she did not experience any special effect from it, excepting that it kept her nails sound.

Psoriasis of Nail-bed affecting the Thumbs only—A senile form.

Mr. P——, aged 64, an hotel-keeper, consulted me on account of symmetrical disease of his thumb-nails. Those of his forefingers were also slightly affected. He had a single patch of dry eczema or eczema psoriasis above his eyebrow. The disease of the nails had been present fifteen months and was increasing. My notes do not describe it in

detail, and I saw him only once. The patch on his forehead had been called eczema, but it was indistinguishable from common psoriasis.

Detachment of the Nails and great accumulation of Epidermis between the nail and its bed—Extensive Eczema—Death from Rheumatic Arthritis.

Dr. Calwell, of Belfast, was good enough to send me the photograph from a patient under his care in whom chronic inflammation of the nail-bed had occurred in association with rheumatic arthritis and attacks of eczema. Dr. Calwell stated that there was great hypertrophy of the nail-bed, producing large masses of mortar-like material which lifted up the nail sometimes even to a right angle with the axis of the finger, and caused it in many to break off short. The nails of both hands and feet were affected, but on some of the digits they escaped. The disease had begun while the patient was undergoing a "crisis" at a hydropathic establishment. At the time of the treatment he was suffering from very extensive eczema, and whilst under it he lost flesh very much. Death occurred in connection with the rheumatic arthritis not long afterwards.

Dusky Congestion of distal part of the Nail-bed as the concomitant of Psoriasis.

In the case of a Mrs. D—— who had suffered from psoriasis of the nail-bed I have preserved the following note: "The nails still show a broad dusky band beginning from free border and extending halfway to lunula. It is broadest in the little finger and diminishes to the thumb the reverse of the lunula. To-day it is not purple, but dusky red. It is entirely removed by pressure."

Nail-disease in association with Psoriasis on Elbows—Nail-bed not implicated.

A Dr. R—— who consulted me in September, 1878, had many of his finger nails pricked, pitted, and uneven. They were not thickened, nor did they become loose. The changes

took place chiefly in their distal halves. The condition had been present only a few months and was associated with scaly patches on elbows, this latter being the only evidence to tendency to psoriasis. He appeared to be in excellent health. There was a remote history of syphilis, but no evidence of existing taint. I ordered full doses of arsenic.

Psoriasis of the Nail-bed detaching the Nails in almost their whole extent and causing exfoliation of some—Patient's father for ten years the subject of Psoriasis.

The following notes are additional to a narrative given at p. 371 of Vol. VIII. and summarised at p. 160 (case 5) of my last issue. The patient, a young man of 21, had all his nails become detached from their beds, the loosening beginning at their free edges. He was produced at one of the meetings of the Dermatological Congress and at several of my clinical demonstrations. The patient himself had no skin disease, but his father had been for many years the subject of psoriasis. It is to be noted that five or six years previously he had shed the nails of his great toes without inconvenience, new and sound ones being at once reproduced.*

Plate CLXXIX. illustrates this case. It is one of the most characteristic and extensive which I have to produce in illustration of psoriasis of the nail-bed.

Additional notes to Mr. M——'s case.

His father had no skin-disease till 86, just about the time of our patient's birth. The father is just rid of his psoriasis, the first time for ten years.

Dec. 29, 1896.—One toe nail, big one, has come off and the other is about to fall. They break through near the root. The others of fingers much as they were. His two thumb nails are less affected than the others. I gave him m. vj of Liq. Arsenicalis. He thinks that it purged, and he left it off for a time. His nails tend to become convex. They grow very slowly and he does not cut them once a month.

* I am acquainted with another case in which a middle-aged man shed the nails of his great toes and had new ones produced, and in which, as in the above, one parent (his mother) was the subject of chronic psoriasis. In him, during thirty years that have since passed, no further disease of nails or of skin has shown itself.

PLATE CLXXIX.

PSORIASIS OF NAIL-BED, WITH EXTENSIVE DETACHMENT.



IN this Plate, which shows the hands of Mr. ———, the nails are seen to be loosened from their bed through more than half their length. It is a typical condition of psoriasis of the nail-bed. The patient himself had no skin disease, but his father had for years been the subject of common psoriasis. (See case, page 214.)

PLATE CXXIX.

TOOTHACHE OF A CHILD, WITH LATE STAGE OF PULPITIS.

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In this Plate, which shows the buccal of Mrs. —, the teeth are seen to be loosened from the socket, the sign in evidence of their looseness. It is a typical condition of pulpitis of the tooth. The patient himself had no pain, however, but his mother, a few years since the subject of common pulpitis. (See also p. 100.)

PLATE CLXXVIII.

PSORIASIS OF NAIL-BED, WITH DISTAL DESTRUCTION.

IN this Plate are represented the nails of the right hand of Mr. ——— (see page 215). This was a case of psoriasis of the nail-bed, with the peculiarity that not only were the distal portions loosened, but broken away. It will be seen that the roots of the nails for the most part still remain unimplicated.



PLATE CLXXVIII.

FIGURES 8-10. MOUNTED, WITH DETAIL DESTRUCTION.



In this Plate are represented the molds of the tail-mould
Mr. ——— (see page 200). This was a case of preservation of the
tail-bed, with the peculiarity that not only were the distal vertebrae
loosened, but broken away. It will be seen that the roots of the
molds for the most part still remain unimplicated.

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Feb. 17, 1897.—Arrest of nail growth is a definite feature. One nail which came off two months ago has not been reproduced. His great toe nail was shed and has been reproduced in a rugged condition; no smooth surface. He has acne of face and numerous white milium spots on eyelids. The process of loosening still progresses. He has taken Liq. Arsenic. m: vj ter die regularly. His tongue shows a whitish ill-defined patch on right side, and the enlarged papillæ are distinctly hard and rough.

He shows me to-day large red patches in the soles of his feet, and complains that his soles are tender in standing. He has to stand much. No arsenical symptoms in eyes or palms. The arsenic appears to have agreed well, but it is perhaps responsible for the inflamed soles. He has noticed that his hands tremble, whereas they used to be very steady.

An affection of the Nail-bed resembling that of Psoriasis, but resulting in the destruction of the distal portions of the Nails—No disease of the skin.

The following case is that illustrated by Plate CLXXVIII. The patient, Mr. M., was sent to me by Mr. Curgenvén. He was twenty-three years of age and his nails had been affected about eight months. The disease was symmetrical, beginning at free extremities and gradually destroying the edge and passing down towards the root. The root, lunula, &c., was mostly free from disease, and the still remaining proximal half or third of nail bright and smooth. In some almost the whole nail was destroyed. The exposed nail-bed was dry and fibrous. The symmetry in the two hands was exact. The toe nails were more extensively involved than those of the fingers. No skin-disease was present, except a little acne on the shoulders. In some instances the destruction of the nail spreads down the side of the nail, leaving in the middle a sort of tongue of healthy nail. This is best seen in the case of the thumb. He had had no pain or inconvenience.

Psoriasis of the Thumb Nails in a Child whose father had a patch of Psoriasis on his elbow.

The Rev. Mr. O—— came to consult me about pruritus ani in his own person and disease of the thumb nails in his daughter. The latter was a girl of nine, in excellent health, who for two years past had the nails of her two thumbs prone to become detached at their free borders and to break.

The conditions were exactly symmetrical, and as the tissue edges of the nails had broken away a certain portion of the nail-bed in a rough, dry condition had been exposed. The parts about the nail-root were quite sound, and so were all the other nails. It was a typically psoriasis condition. I was told that she had no trace of skin-disease elsewhere, and an inquiry whether any relative had been the subject of "psoriasis" was answered in the negative. The nails had already had a certain amount of treatment, and one of them when at its worst had been removed. The new nail had, however, reproduced precisely the original conditions.

We now turn to the father's case. He had a whitened condition of the skin at the verge of the anus, which was also thrown into folds, a very ordinary state in pruritus ani. He told me that at one time redness and irritation had extended upon the buttock, but not of late. He added that the only other form of skin-disease which he had was a patch on one elbow. On exposing the latter he showed me a characteristic patch of psoriasis just below the olecranon.

Thus it will be seen that we had in the father's patch an interesting confirmation of the correctness of the diagnosis of his daughter's nail-disease as being of the nature of psoriasis. The case adds another to the numerous instances of transmutation of disease in transmission from parent to offspring. The transmutation is, however, not great, and perhaps we ought rather to say that the daughter as yet shows only part of her inheritance. She may at some future time become the subject of psoriasis of the skin.

Psoriasis of the Nail-bed in a Middle-aged Woman without other disease of the skin.

Miss T——, aged 39, from Clacton, consulted me on October 16, 1897, and again on February 23, 1898. The nails were loose at their borders and discoloured by epidermis beneath them. She had no skin-disease. The nail affection had begun, a year before I first saw her, on the middle finger of the right hand, and subsequently extended to others, but the two ulnar fingers on each hand escaped, as also the thumb on the right. She complained that her

finger-ends sometimes ached and felt hot. This happened sometimes to one finger and sometimes to another.

A solution of tar relieved the aching, and under long courses of arsenic the nails got almost well. She took the arsenic in six-minim doses three times a day, but was obliged sometimes to omit it, as it seemed to cause pain at the epigastrium.

Although the condition was typically that of psoriasis of the nail-bed, I could not obtain any history of family tendency to skin diseases.

Miss T—— attended once or twice at my Demonstrations.

Chronic Affection of the Nail-bed in a Child—One Hand only affected—No Fungus found—Family history of Eczema, &c.—Exfoliation of Nails and reproduction.

Mary H——, a healthy-looking child, aged $4\frac{1}{2}$ years, was brought to me on July 24, 1890, on account of an affection of the nails. It had begun on the little finger at the age of ten months, when the nail fell off. When I saw her all the nails of the right hand, excepting that of the middle finger, were involved. The left hand was quite free. Although it had been better at times, yet the disease had never been quite cured. It was reported that, when the nails improved, some spots came on her knees, &c. They had been called "scurvy spots," and were probably a form of psoriasis. Several of the nails had fallen off, but they had been quickly reproduced. Sometimes the front part of the nail had become detached, so that it had been necessary to cut it away for fear of its being torn off. Her mother thought that she played with her hands in water, and that the nails quickly "rotted and loosened." The ends of her finger pulps sometimes peeled, and her mother was liable to the same thing, and also to peeling in the palms in small spots. There was no history of ringworm, but I elicited some as to family tendency to skin-disease. Her mother, in addition to the affection of the hands (of which cracks were still to be seen), stated that she had had "a dreadful head" in childhood. One of her brothers, aged 6, was liable to spots like "chicken pox," and also to patches

which come out on his knees, &c., after a warm bath. The state of the nails in this case is illustrated in Plate 174.

On August 13th I saw her again. She was taking arsenic in two-minim doses of Fowler's solution, and it suited her and the nails were improving. I have no later notes as to progress.

If this case be accepted, as I think it must, as an example of an affection of the nail-bed allied to psoriasis, it is to be noted as exceptional that only one hand was affected and of it not all the fingers.

Disease of the Nails in a young girl in association with a mixed form of Lichen-Psoriasis.

The case of Miss H——, who was sent to me from Leicester, was of much interest, as illustrating the association of disease of the nails with a skin eruption. She was a pretty girl, of florid complexion, aged 9. At the age of two her finger-nails had begun to suffer, and about the same time she became liable to dry patches on her knees and elbows. Her nails had been called "oyster-shell nails," an expression which was very fairly descriptive of their appearance. Before I saw her she had been for long under the care of an able specialist, who had considered it to be a sign of gout, and had given iodide of potassium. This salt had made her feel very languid, and no appreciable benefit had accrued to the nails. The appearance of the nails and the history of its having commenced at so early an age made me suspect that it might be ringworm, and this suggestion seemed to be supported by the history that both the patient and her sister had had patches on the scalp. I made careful microscopic examination of parings from the nails and could find no fungus; and there appeared reason to believe that the spots on the scalp had been parts of the general eruption and not parasitic. When I first saw Miss H—— on August 1, 1894, all her finger nails were opaque and rough, and some of them much thickened and fibrous. In paring one of them, which was especially thick and horny, bleeding was caused. None of them were, in any material degree, detached. Only one of the toe nails had suffered.

The skin eruption consisted of some dry scaly patches on the backs of her forearms, in the clefts between the thumb and forefinger, on the fronts of the knees, and in the popliteal spaces. None of these were in a characteristically psoriasis condition, and in some a lichenoid enlargement of the hair follicles was conspicuous. This was especially the case with the popliteal patches, which were "rough as a nutmeg-grater." There was no history of skin-disease in the child's family, with the exception of what has been mentioned in her sister. I prescribed arsenic and a chrysophanic acid ointment, advising also that the nails should be carefully scraped down.

On November 1, three months after her first visit, Miss H—— was brought to me again. The remedies had agreed well, and her nails were very much improved. None of them were in the least thickened, and some were almost smooth on the surface. They were, however, thin and weak, and all of them showed the pin-pricked condition, which is, I think, frequently seen in eczema. Most of the patches on the skin had also much improved, and those on the knees and elbows were almost well.

A mixed form of Chronic Nail-disease in association with Psoriasis-Eczema and Gout.

A surgeon who was acquainted with my statements as to the form taken usually by true psoriasis of the nails, showed me his own fingers as affording an exception. "I have psoriasis," he said, "and I have nail-disease, but the latter does not always begin, as you say, at the sides or free edge, but sometimes at the root." He had already shown his nails in reference to this point to a distinguished specialist. I found his nails in part exceptional and in part not so. Several of them showed the usual conditions of psoriasis, that is loosening of the nail from its bed and the accumulation of dirty-grey epidermis between the two. He assured me, however, that in several nails changes had begun at their roots, and that they had shown surface changes. Of these one or two showed some slight evidence. I now asked to be shown the "psoriasis." It consisted in a few

patches of what I should have called "dry eczema," and which were not placed in the psoriasis positions. My friend was in excellent health, but "very gouty." He had some dry seborrhœic eczema behind his ears. His skin disease had in former times been called "psoriasis" by good authorities, but I feel sure that it was a mixed form, and in this it corresponded well with the mixed features displayed by his nails.

Description of the state of the Nails in a case in which an elderly lady was the subject of Eczema-Psoriasis.

The case of a lady named C—— might at first sight have seemed to afford an excellent opportunity for studying disease of the nails in association with psoriasis. She had suffered for two years from severe psoriasis attended by affection of the nails, and in the autumn of 1893, after being for a time in bed, she got quite rid of both under tar baths and antimony. For eight months she was quite well, and then a relapse occurred in which her nails began to suffer before the skin. All the nails were affected, whilst as yet a single patch on one elbow-tip, was all she could show on the skin. Now the type taken by the onychitis was that of longitudinal fluting, rather than that of loosening of the nail border. A few of them showed the latter change (which I regard as typical of psoriasis of the nails), but all were rough and broken on their surfaces in lines extending from the lunula to the tip.

The deviation from type was, however, perhaps less real than it may appear, for the type of psoriasis was peculiar, and the patient was at the same time the subject of acro-arthritis. Some of the terminal joints of her fingers were deformed by rheumatic gout. Our patient was sixty-one years of age, and she inherited gout. Her nails might therefore be supposed to be in some degree influenced by acro-conditions. That they were in the main, however, implicated in association with the skin was made probable by the fact that they suffered severely during the former attack and had got well when it was cured. A few words must therefore be said as to the precise character of the skin eruption. In the first

PLATE CXXXVII.

PSORIASIS OF NAIL-BED WITH ECZEMATOUS COMPLICATION.

(TYPICAL PSORIASIS OF NAIL-BED.)

THIS Plate shows the condition of the nails in Mrs. C.'s case (see text, page 220). Mrs. C. was the subject of typical psoriasis, but she had also eczematous complications. It will be seen that on the digits which show congestion and peeling of the skin the nails are implicated at their roots and on their surfaces, as well as at their free edges.

The two digits on the left hand of the Plate are from another case, and show the typical conditions of psoriasis of the nail-bed, the nails being loosened at their distal extremities. They are two fore fingers from the same patient. (Dr. E.)

PLATE CXXXVI.

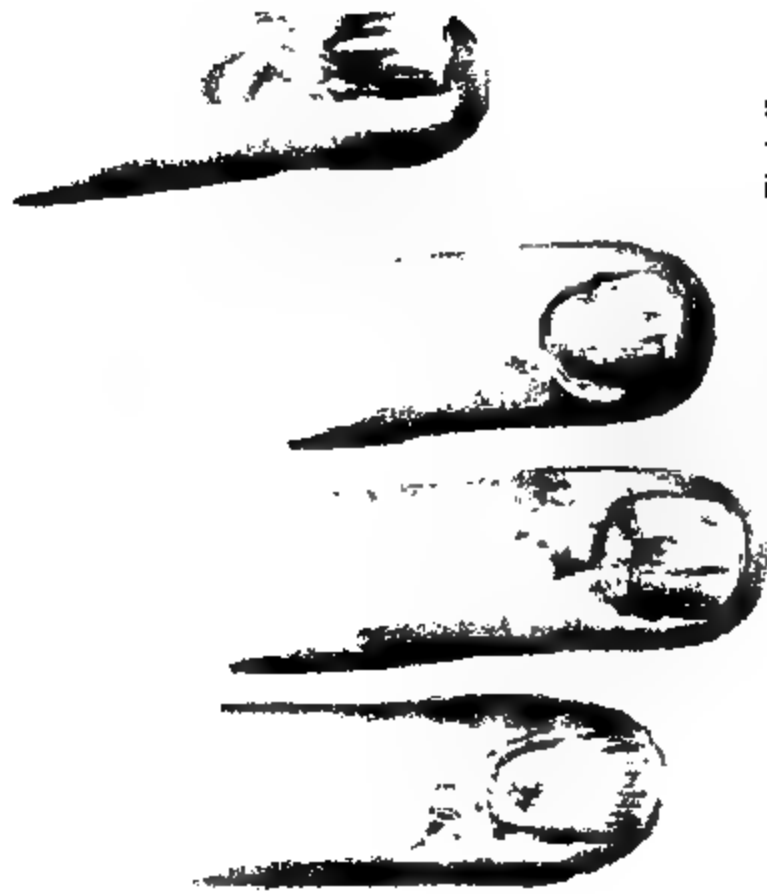
PSORIASIS OF NAIL BED WITH ECZEMA OF SKIN COMPLICATION.

Typical Psoriasis of Nail-bed



This Plate shows the condition of the nails in Mrs. C.'s case (see text, page 92). Mrs. C. was the subject of typical psoriasis, and she had also eczema of the skin. It will be seen that in the digits which show congestion and peeling of the skin the nails are implanted at their roots and on their surfaces, as well as on their free edges.

The two digits on the left hand of the Plate are from another case, and show the typical conditions of psoriasis of the nail-bed, the nails being loosened at their distal extremities. They are therefore from the same patient. (Dr. E.)



West, Newman choroio.

[illegible]

instance I had named it eczema-psoriasis, and had described it as "very large ham-coloured patches on backs of arms and hands. It occurs also as nummular patches on limbs and body. The upper parts of the shoulders and the face are free, but some spots are found on the scalp and behind the ears. The backs of the hands are covered, but the palms only slightly affected. The nails are broken up and fibrous, the affection beginning simultaneously at their roots and tips. The ends of all her digits, fingers and toes alike, are dry and cracked, and in some cases there are cracks in the clefts." These notes were written in September, 1893. There was a tradition that an aunt had suffered from psoriasis, and although I regarded the case as approaching nummular eczema rather than typical psoriasis, I prescribed for it as being the latter. The arsenic and chrysophanic acid ointment did not, however, suit, and a month later she was confined to bed with an acute and almost universal (though still not diffuse) dermatitis. From this she recovered completely under antimony and tar baths (as already stated in the preamble), and regained a perfectly soft and healthy skin and sound nails. The mode of recovery and its completeness certainly indicated an eczematous dermatitis rather than psoriasis. Yet on the occasion of the relapse as noted, the first patch showed itself on the tip of one elbow.

If I were to trust to my own creed I should regard this case as a good example of the mixed form of disease partaking of the characters of both psoriasis and eczema. In the light of such an hypothesis, it is not surprising that the disease of the nails did not keep to the type of either.

Plate CXXXVII. shows the state of Mrs. C——'s nails at the date of the subjoined note.

January 15, 1895.—Mrs. C——. Her psoriasis is still coming out, but is much less irritable. It is in the characteristic positions. Miss Green has taken a sketch of her finger nails. She has taken antimony for a month and feels well (grain $\frac{1}{2}$); good appetite, much less inflammation. She has a tar bath nearly every night. We have never given thyroid extract.

Mixed conditions of disease in all the Nails in association with Seborrhœic Eczema of other parts.

Miss S——'s case is one in which universal nail-disease was coincident with seborrhœic eczema on the scalp and eczema of the genitals. The eczema did not tend to the sycosis type, and her pubic hair was not affected. The labia and adjacent parts, margins of anus, &c., were red, swollen, and moist. On these parts the type seemed to be an eczema madidans, but it had probably been aggravated by rubbing and scratching. On the scalp, when I saw her for a second time in September, 1898 (two years after her first visit), the condition was one of partial cure by tar lotions and mercurial ointment, but still kept up by continual scratching. There were ill-defined patches of eczema with seborrhœic crusts in many parts. The hair had been made rather thin, but was otherwise not implicated. She had a clear complexion, and the skin on all other parts was quite free from disease.

It was her nails which gave Miss S—— her chief annoyance. These were all affected, both those of the toes as well as those of the fingers, and not a single one had escaped. The ends of all the digits were somewhat congested, and looked red, but there was no moist secretion. The nails were rough, fibrous, pitted, and broken over their whole extent. The conditions were least marked at their roots. At their free edges they were undermined to a certain extent (the psoriasis state). This was quite definite, and conclusively proves that the nail-bed was affected. None of the nails had been shed.

The statements just made describe the conditions present at the date of Miss S——'s second visit. On referring to my former notes (two years and a half earlier), I found that at that time the roots of the nails were more definitely affected, and that there had occasionally been some discharge from them. I had then thought that the inflammation began at the root. Almost the whole scalp was then involved in dry seborrhœic eczema, which was limited to the hairy parts. The history then given was that the

nails had been affected for sixteen years, and that the disease had begun in one toe nail. Miss S—— was, however, subsequently uncertain as to this, and thought that a patch in one thigh had been the beginning. Probably the scalp really had taken precedence, but her mother assured me that in childhood the girl had no disease of either skin or scalp. She herself (the mother) had suffered from eczema, and two of her sons had been under my care “for boils.” Miss S——, who was a Jewess, had delicate features and very fine hair.

As to previous treatment, Miss S—— had been for many years under the care of Dr. L——, who had usually prescribed arsenic. This had been pushed until her skin was made brown and dry, but had never done the nails any good. Her skin was, she thought, habitually dry; she neither perspired easily, nor did she get heated by exercise.

It seems probable that we have in this instance an hereditary tendency to eczema, possibly of the psoriasis type. The onychitis was of a mixed form, in part affecting the surface of the nail and beginning at the root, and in part the nail-bed and beginning near the free edge. It is not probable that the eczematous process had spread from one part to another by direct contagion. The exemption of the general surface, and the symmetry and universality of the affection of the nails, are facts in favour of constitutional rather than local origin. I saw Miss S—— first in February, 1896. A note in October, 1898, states that her health had much improved, but not so her nails.

Psoriasis of Nail-bed with ill-characterised Psoriasis of Skin.

Miss S——, æt. 37. It is the psoriasis condition very marked on the nails of middle, ring, and thumb. Little finger and forefinger quite smooth. Thumb nails corrugated, those of ring and middle fingers simply undermined. She has no patches on elbows, but has had some on face. There are large rough patches on her knees, but they are not characteristically psoriasis. She had patches, she says, on backs of hands and on ankles about the time that her nails began to suffer. All the nails on the right foot are

affected in the same way, accumulation of epidermis under them. The nails of the other foot are as yet sound.

She is rather stout, and is pale. She says that she must take iron frequently or she becomes anæmic. Her mother and an aunt had some eruption on the face. The nails are loose and discoloured for two-thirds of their length, the lunula being unaffected and the surfaces smooth. The little finger of left hand shows the disease in its first stage, a band of dull-red congestion extending from the free edge upwards for an eighth of an inch.

It began in March, 1895, and was worse then than now. Complains much of feeling very weak. Always delicate although stout. She has already taken arsenic, and her eyes prick.

Psoriasis-Eczema of Finger Nails.

Mr. H——, æt. 52. His nails have been liable to suffer since 1891. It followed a very severe attack of influenza. It has varied from nail to nail. Sometimes it begins at the free edge, very definitely in some, and in others on the surface over the lunula. He thinks that the nails have all suffered in turn, but not all at once. Some are pin-pricked. They recover almost perfect smoothness.

His toe nails crack and break, but have nothing like those of his fingers. His finger nails are worse now than ever before.

He has had a patch of chronic eczema on his scrotum, almost dry and very irritable, "for years and years," twenty at least. He once had "dry eczema" on the tips of elbows. His father had eczema and gout, and his uncles had gout.

He is the subject of bronchial asthma. Twenty years ago, under a French doctor for asthma, he took arsenic, after which he had a long attack of diarrhœa which was attributed to it. His circulation is easily disturbed. Very cold extremities in cold weather, and much perspiration in hot. He has habitual diarrhœa, thin, liquid motions every morning.

A mixed form of Nail-disease in association with Psoriasis and Eczema.

Mrs. C——, of C——, æt. 50, came to me Feb. 23, 1884, for an eczematous condition of her nails. She was married, and had five children, none of whom had skin-disease. In girlhood she had suffered from common psoriasis on the tips of elbows and fronts of knees. It lasted on and off several years, and she probably took arsenic. She was married at twenty-two, and was free from all skin-disease during six pregnancies and lactations. She had abscesses in armpits (sycosis axillaris), and also suffered from quinsies. Until September last she had had no skin-disease since the psoriasis, which ended at eighteen or nineteen. In September last cracks began to form at the roots of the nails, and then all the quicks of the nails inflamed. There was much irritation, and much watery discharge. She was much out of health at the time from over-nursing her husband. The ends of the fingers were inflamed and red, with cracking, exfoliation, and eczematous condition over the pulps. The nails were all thickened, fibrous, and broken away in front. On the palmar aspects of the hands were several patches of peeling eczema. Her toes were affected also, especially those of the left foot. It began at the tips of the toes, and apparently attacked the nails as part of the region. She had no eczema anywhere else. She was pale, and the menstruation was irregular. On August 31st her fingers were better, but not well. All her toe-nails were in exactly the same condition, thickened, dry, and cracked. She had no other skin-disease, except a thickened hard state over the heels. Arsenic in full doses had suited well; it had been given combined with nux vomica, nepenthe, and alkali. She had taken the arsenic since February 24th, with only a week's intermission now and then. She was able to sleep better; formerly she could not sleep on account of the pain. On Jan. 5, 1885, her finger- and toe-nails, although not well, were much better. She kept them well by constantly using the tar lotion, and had taken no medicine for four months. The ends of the fingers still peeled and cracked.

On March 12, 1890, Mrs. C—— consulted me for a pruriginous eruption on her thighs, allied to lichen ruber. She was thin and pale, and had a poor appetite. Her nails had long been well. Mrs. Norwood, her daughter, consulted me a few months later and reported her mother well.

Feb. 14, 1890.—Mrs. C——, æt. 55, from Somerset. Her nails and finger-ends. I have not seen her for three or four years. She was nearly well when I last saw her. Under the arsenic and tar wash she got well. She left off the arsenic three years ago, but has continued the use of the tar wash ever since. She has the utmost faith in the tar wash; says it always cures any cracks which threaten.

She now comes on account of eczema on the genitals. It has been present on and off for two years. She looks rather pale and thin. Her finger-ends are quite well, and the nails smooth. They have been so for long.

Chronic disease of Finger-Nails—Tendency to Dry Eczema of various parts of the body.

Mr. W. W. P——, a married man, aged 43, an engineer from S——, in excellent health, consulted me on May 4, 1892. His nails had always been thin and flat, but had not been noticeably diseased until two months before. The disease then began in the left forefinger. It began at the root, the nail becoming thin and fibrous, and showing crumpling with transverse ridges. Finally the nail became broken into fibres, some of them pitted with little white dots. There was some redness of the skin around the nails; but no moist discharge, and no pain. The left hand had suffered most, all the fingers being involved, and only the thumb escaping; as had also the thumb of the other hand. The toes had not been threatened. There was no skin disease in the family; but Mr. P—— remembered that twenty years before he had had for two or three years a dry patch on the front of one leg. It gave no trouble, and finally went away of itself. I also found, on further search, a sort of dry eczema on the right ankle.

Mr. P—— was a man of dark complexion, stout and

florid, and accustomed to take whisky, but no other stimulant.

On May 19th, all the soreness at the roots of the nails had disappeared under arsenic. There was a little dry eczema on the left ear.

Disease of Nails in association with ill-characterised Psoriasis of Skin.

An important illustration of the association of nail-disease with an eruption of the skin came under my notice in the person of Mr. C. J——. This gentleman was 40 years of age and in excellent health. He had lived some years in India, and his eruption, &c., began whilst there. He had once had soft sores, but never any constitutional symptoms. The affection of his nails and that of his skin began almost simultaneously about six months before I saw him. His visit to me was on June 5, 1899.

State of his Nails.—All the nails of both hands and both feet are affected, and in all the disease is of the same type. There is no obvious congestion at the root of the nails, but close under the nail-fold the disease begins by the formation of a transverse furrow. In this furrow the surface of the nail is broken and roughened. All in front of the furrow is perfectly round and smooth, but as the nail grows forward the diseased portion comes to involve more and more of the nail surface. Finally the last portion of smooth nail is pushed over the end, and there remains nothing but a fine fibrous structure occupying the nail-bed. His own expression was, “These nails, you see, are gone altogether.” The conditions described were well seen in the nails of his great toes, which had been only recently attacked and were exactly alike. About a third of the nail from its root was involved, the anterior two-thirds being still thick, smooth, and polished.

The skin-disease which accompanied the affection of the nails above described consisted of ill-defined patches of a thinly scaly dermatitis on the fronts of both legs and on the feet. These extended on the latter on to the soles. There was some erythematous congestion, but no discharge. The knees and elbows were not affected, but on the backs of his

forearms I found a slight tendency to the same kind of dermatitis, but it was so slight and indefinite that he had overlooked it. The eruption had been called psoriasis by a surgeon who had seen it, but it differed much from ordinary types of that disease. None of the patches were circumscribed; they were congested and but little scaly, and they avoided the psoriasis positions. It was, however, a symmetrical eruption, and probably due to some influence working from within. In this feature it fitted well with the nail-disease, and the two had commenced almost together.

There was no history of skin diseases in the patient's family, and he had never suffered previously. He had probably taken stimulants rather freely.

It should be added that he believed that he had in India repeatedly suffered from ringworm, but not for some years. That the present attack had nothing to do with ringworm was clear from its sudden development and symmetrical distribution, every nail in the four limbs being affected.

On the whole, I think it probable that the attack does represent a malady essentially allied to psoriasis, and if so, it is of great interest to observe that both the skin eruption and the nail-disease differed much from the typical form.

As regards the influence of remedies, Mr. J—— believed that he had been taking arsenic for five months before I saw him, and without any benefit. He said that once in every few weeks it had caused an attack of sickness and pain at stomach, but he had been able to resume it.

Infantile Eczema with Disease of Nails.

Dr. W——'s infant was eighteen months of age, and the youngest of three children, when I was first consulted in 1891. I was told that his mother had had eczema repeatedly, and severe attacks, and that two of the other children had each had a few spots, but never enough to require treatment. He had been vaccinated from calf lymph at the age of three months, and although the pocks inflamed, they ultimately did well, and there was no eruption. His eczema began at the age of six months on the face and arms, and was thought to be worse in cold weather. There had never been much

PLATE CLXXV.

**DISEASE OF NAILS IN ASSOCIATION WITH ECZEMA
IN A CHILD.**



**THIS Plate shows the condition of the nails and ends of digits
in the case of Master E. W. (See case narrative, page 229.)**

NSUN 5 6 10 12 14
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

PLATE CLXXV.

PLATE CLXXV.

RELEASE OF NAILS IN ASSOCIATION WITH SCURVY
IN A CHILD.



THE Plate shows the condition of the nails and ends of the fingers
in the case of Maria E. W. (See case narrative, p. 299)



on the scalp. The child was in fair health and had grown well, but was very pale. On one occasion he had been taken to Brighton and allowed to live in the open air, when his eczema got quite well. It relapsed, however, when he returned home.

The interest of the case in reference to the present subject is that in connection with the eczema the finger-ends and the nails had become affected, and that the conditions were sufficiently marked to be thought worthy of a portrait. When brought to me the eczema affected the arms, face, and back, but also in some degree the palms and palmar aspects of fingers. The nails were pitted on their surfaces. Some years later I saw the child again, the disease then persisting only on the hands and the nails. The eczema on other parts had been cured by tar washes, &c.

Eric W—— was brought to me for a third time in March, 1899. He was now ten years old, tall, thin, and pale. His parents had for six years past left Woodstock, and had resided at a warm and relaxing town in Devonshire. The boy's liability to asthma, bronchitis, and spasmodic croup had still continued, and he had often been laid up in bed for a week or two at a time. He was liable to attacks in which the temperature would be high in the morning and normal in the evening. He could not run or play with other boys, because it brought on short-breath and an attack of asthma. He had remained quite well as regards eczema since my last treatment for it, and his skin was now everywhere sound excepting his finger-ends. Some of his fingers were quite well and their nails smooth, but I was told that all had at one time or other suffered, many of them still did, and were rugged and broken on their surfaces, or deeply marked by transverse furrows which did not cross the whole nail. As these were not alike in position on different nails, it might perhaps be supposed that they were not the records of illness, but rather the results of the chronic onychitis. I think it more probable, however, that the present condition of his nails is due to a complicated causation. He had originally unusually hard and brightly polished nails for a child. His father tells me that I remarked upon their

condition the first time I saw him, and said that I had never seen such nails in a child. They were at that time not diseased. Now it is precisely in nails of this kind that transverse furrows may be produced, some thickness and density of nail being essential in order to permit of their development. In this boy's case, at the present date, the nails present several different features. Not only do some of them show deep transverse furrows, but they are rugged and broken on other parts, and more or less undermined at their edges. The radial digits have suffered most, and on one hand the little finger is quite free and on the other almost so. The integument around the borders of the nail is more or less broken and scaly, and I am told that sometimes deep cracks occur in the pulp of the finger-end. His fingers and nails are said to be always worse if he is allowed to play in the garden, and get better when he is confined to bed by illness. Thus we may assume that there is a condition of chronic acro-dermatitis in which his nails are involved. Some of his illnesses have been attended by high fever and great subsequent exhaustion, so that they have been quite sufficiently severe to account for the occurrence of transverse furrows. A very peculiar feature in the case is an apparent advance of the lunula in some of the nails. Thus in one forefinger it comes much further forward than it does in the other, and the nail being thick, it has assumed a dense pearly appearance. There is much gout in his father's family, his grandfather and great-grandfather having both suffered severely from it.

He has two elder brothers, neither of whom suffered from either eczema or bronchitis. As regards the influence of climate, I am told that he was once very ill at Ventnor, and that he was unusually well and free from symptoms during a visit to Torquay (staying on the esplanade). His mother mentions as a curious symptom that he cannot kneel long, and that he has oppression of breathing and turns faint when kneeling at church. I have advised that a complete change of air should be secured, and that he should take minute doses of antimony.

Chronic Nail-disease in association with Lichen Planus.

Mr. S——, æt. 43, married, healthy children, never had syphilis. Extensive disease of nails. They become first thin and fluted, and then break up. The nails of most of his fingers have been in this way almost destroyed. The distal portions have broken away, and in some cases a hole has been eaten quite through the nail. No accumulation of epidermis under the nail. He is a traveller in cigars, and smokes and drinks freely, but is in excellent health.

Some of the nails are more affected along their centres than at the sides (like Mr. H——'s), and look as if punched. Some, although thinned, are very hard. All are opaque and discoloured. They have given him no pain. The lunula is in all cases quite lost. I think that the disease begins at the lunula. He has no patches on the tongue, but some slightly marked in cheeks. The toe-nails are thick and curved and opaque, and do not grow forwards.

At first he denied any skin-disease, but on being pressed said that some patches were just come on his back. On stripping him I found on the loins and sides of abdomen a number of polished spots and patches. These were on the left loin confluent into large patches; on other parts they were seldom bigger than split peas. He had none elsewhere excepting some very small ones in fronts of wrists. He has had his nails affected for eighteen months, but the eruption has been noticed only a month or two. He has dry, polished patches.

(To be continued.)

ON SYCOSIS-KELOID.

I HAVE referred at page 131, Vol. IV., to a peculiar and rare affection of the skin, which I ventured to name Sycosis-keloid. It had previously been ably described by Dr. Marrant Baker* under the name of "Acne-keloid," and by several French writers. Its precise name does not so much matter if we can grasp the fact that on certain regions of the body keloid indurations may form and advance, the first stage of which has been chronic pustular inflammation around hair follicles. The nape of the neck is the common site of this affection, but not the only one. Permit me at the outset to insist that there are various degrees and modifications of the several morbid processes which, in association, contribute to make up typically developed examples of the malady. We must not restrict our attention to well characterised examples solely.

As a rule I endeavour to avoid in my ARCHIVES all discussions of the opinions of others, and to confine myself to my own observations. It is desirable, however, here to record my opinion that the terms "Acne-keloid" and "Sycosis-keloid" are both of them pathologically applicable, and that the term "Dermatitis papillaris capillitic" is not so. Quite different maladies have been brought together under the same name. The disease with which we are concerned is not in the least papillary; no trace of a warty growth is to be observed. On the contrary, it does begin by indolent

*. Mr. Marrant Baker's paper is in vol. xxxiii. of the Pathological Society's Transactions, and is a piece of excellent descriptive writing. He and I agree entirely in our opinions. He mentions two cases, in one of which he had effected a cure by cauterisations with nitric acid. He believed his cases to be the first recorded in England, but if so I cannot help saying that at the date he wrote (1882) I was myself quite familiar with the malady.

sycotic or acneiform tubercles. Nor has it anything in common excepting its site, Alibert's *Pian ruboide*. It never runs a malignant course, although I do not doubt that it is related in hereditary descent with cancerous tendency. This feature it has in common with the other forms of keloid. It is by no means so rare a malady as some authors would have us to believe. I have seen more than a very few examples, and have kept several drawings. Its initial stage of indolent pruriginous tubercles of the nape is indeed quite common, and not infrequently these indurate more or less. Cases as advanced and as well characterised as that now figured are undoubtedly rare. The term "*Sycosis framboesiformis*" given by Hebra to certain cases recorded and figured by him, but quite distinct from the present malady, is wholly inapplicable to it.

The features which make the diagnosis are the smoothness of the surface, the absence of papillary growth, the density and thickness of the new formation, the abruptness of the border, and the collection of the hairs into tufts. They are all well illustrated in the appended woodcut.

Extensive Sycosis-Keloid of the Nape—Restoration of the Skin in some parts to perfect soundness—Use of Cautey.

I have recently had an opportunity for studying the peculiar features of this malady in some detail in the case of a man named P——. The general appearance of his nape is represented in the accompanying illustration. A thick, broad band of sycosis-keloid extended across his nape, tailing off on each side of the neck. In the middle the patch was broad and smooth, and at least half an inch in thickness, presenting very abruptly elevated borders. At the sides, however, it consisted of a number of hard tubercles, some of them pustular, which had only imperfectly coalesced. Many of these pustules had hairs in their centres, and were obviously formed around hair follicles. On the central part there were no single hairs to be seen, but many tufts like those of a brush. I counted in some of these tufts, making their exit at one aperture, as many

as thirty hairs. On pulling out a tuft it was easily seen that the concealed portions were of very different lengths. In some a portion of hair-shaft half an inch long was embedded before the root was reached, whilst in others in the same bundle only the eighth of an inch. The bundles were by no means very firmly fixed, and usually the inner hair-sheath in a softened state came with the hair.

I did my best to observe how the hairs became collected into tufts. At the margin of the patch were places where aggressive outgrowths had surrounded many hairs, and were about to coalesce, forcing the hairs into the centre of the advancing growth. At other parts a group of separate indolent tubercles would in like manner coalesce and surround a group of adjacent hairs. Many of the hairs had probably been shed, and perhaps in the end all were

destined to be so. A very curious feature favoured this latter observation. It was that a large area of skin immediately below the middle of the keloid patch was absolutely bald. I was assured by my patient that this was the region upon which the disease had in the first instance been present. It was advancing upwards, and leaving its former territory quite sound, not in the least cicatricial, but wholly devoid of hair. This observation interested me much, for I had no idea that such complete restoration by a spontaneous process was possible. It is needless to point out, however, that it accords exactly with what we know of keloid scars, in which complete removal of the new growth is often observed, nothing in the nature of scar being left behind. I have never, however, seen common keloid disappear on one side of the patch whilst advancing on the other.

The history of the patient was that the disease had commenced as a number of indolent pimples in the skin of the nape where the collar rubbed. This beginning was eighteen years ago. At all stages there had been intolerable itching, and the patient had scratched freely, often so as to draw blood. Nine years ago some strong caustics had been applied with much temporary benefit. Mr. P—— was a very robust man of forty-one years of age. One of his maternal uncles was the subject of cancer of the rectum.

In June, 1899, I attempted the destruction of the patch by means of the actual cautery. This was done without anæsthetics, and was borne with heroism during at least ten minutes. I burned up most freely outlying borders and a large portion of the centre, but did not venture, on account of the extent and its great thickness, to destroy quite the whole of it. During the process the cautery repeatedly opened little depôts of thick pus, especially near to the margins, thus confirming the opinion that the disease in its early stages was a follicular inflammation. The burn which was left was very extensive. It cleaned under the use of an iodoform and vaseline ointment in about a fortnight. Although the cautery had been dipped very deeply and used

most freely, I found during the subsequent dressings not nearly all the hairs had been destroyed. They grew up again in many places, either singly or in tufts.

It is too early as yet to report as to the success of the treatment. The cauterisation will no doubt need to be repeated. It is a measure which, however, involves no risk, and not, excepting in the first instance, any pain. In a case in which many years ago I adopted it, the results were very satisfactory. The patient in this case was a lady, and the disease was extensive. I used the cautery myself once very freely, and the cure was completed by several lesser applications of it by the patient's family surgeon.

Impetigo Keloid on the inner side of the Knee.

Although these keloid growths following pustular eruption are seen, I think, in full perfection only on the nape of the neck, yet we now and then see less well-marked examples of the same tendency on other parts. In the case of Miss H——, a lady of thirty-four, who had suffered for twenty years from impetiginoid eczema on the inner side of her right knee, a patch of keloid induration had developed. The characters of the eczema had been somewhat peculiar. It had consisted of an ill-defined group of spots or dry pustules, which itched exceedingly and readily bled when scratched. The keloid had supervened on this during the last three or four years, and now consisted of a patch the size of a five-shilling piece, well-defined, and abruptly elevated on one side, but less well on the other. It was at least a quarter of an inch thick, but its resemblance to typical keloid failed in that its surface was not glossy and smooth, but still a little rough and scaly. Miss H—— told me that it was steadily increasing. It occupied only a small part of the region affected by the impetigo-eczema. I asked Miss H——whether she had any similar patch on the nape of the neck. She told me "No; but I remember that when young I was much troubled by an eruption then like that on my knee." Under treatment this had got quite well.

In reference to the question as to whether the term impetigo or sycosis be the more applicable to the preceding eruption in this case, it must be stated that the latter had an unusual amount of hair on the affected part, at the roots of which apparently the indolent pustules had formed.

Sycosis-Keloid of Nape of eight years' duration.

The initial condition in these cases is not always the same. The most common is, I believe, a chronic sycosis pustule, but sometimes it more nearly resembles an eczematous sycosis. This was the case in the instance of a man named W——, who was sent to me by Dr. White, of Margate. His patch on the nape was as large as the palm of an adult hand, thick in the middle, but shelving off at its margins. At the latter, and extending a little upon the adjacent skin, the conditions were those of a dry eczema. The patch had been present eight years, and was still spreading. It had been very irritable. At one time epithelioma had been suspected, and at another it had been diagnosed as syphilis. There was no history of previous syphilis. The patient was a florid man, but quite temperate in his habits. There was a history that twenty years ago he had had for a long time a patch on his scalp, which he used to scratch habitually whenever engaged in thought. He had also a little dry eczema on his fingers. The patch on the nape had been much scratched; and although eczema-like at its borders, in the middle it was thick and like keloid. The hairs had been almost wholly lost.

Sycosis-Keloid in an early stage.

In July of 1893 a gentleman, aged 30, who had lived much in India, consulted me about some brown spots, like abortive pustules, on his legs. They had been present some months, and he had been told that they were syphilitic. There was, however, not the slightest reason for thinking that he had ever had syphilis. I attributed them to the pricks of thorns or bites of insects, and prescribed accordingly. In June of 1894 the same patient came to me again. His legs had long been well, but he had now some

little scaly spots in his eyebrows and whiskers. They were insignificant, and I again prescribed only local applications. In April, 1899, Mr. H—— for a third time consulted me, and this time his ailment was of more definite interest. For two years past he had been aware of an indolent spot on the nape of his neck which was, he said, slowly increasing in size. He showed me a small but well-characterised example of the sycosis-keloid. It was not larger than a shilling, and a long oval in shape; of a dusky brown tint, abruptly margined and raised by abrupt margins an eighth of an inch above the surrounding skin. The hair upon it was gathered into little tufts. The surrounding skin was normal, and at this date there was no disease of the skin elsewhere. I pulled out all the hairs on the affected part, and then soaked it with fuming nitric acid.

The history in this case seems to connect the disease on the nape with a tendency to disease of hair follicles of a peculiar form of sycosis on other parts. The use of mercurial ointments had cured the disease elsewhere, but this individual spot had been neglected, being out of sight, and had slowly developed features of peculiarity owing to its peculiar site.

Sycosis-Keloid of the Nape and Rhino-scleroma of the Upper Lip in two brothers.

A gentleman named B——, aged 31, showed me a very small patch of this kind. It was on the site of a boil, on the left side of his nape. It was bigger than the tip of the little finger, and had exactly three tufts of hairs on it. It was not quite so brawny as usual. It had not excited much attention, but had probably been present about a year.

A very important point in the case was that Mr. B—— was the brother of the patient from whom I removed by excision and cautery a patch of rhino-scleroma some years ago. A portrait of this patient is preserved. I am told that he remains quite well, and that the scar does not show much.

It is further to be noted that the keloid patient had an attack of acute lichen ruber when he came to me. It did not implicate the back, and was wholly unconnected with his other ailment.

A CASE OF ACUTE HERPETIC PEMPHIGUS.

FOR the two letters which I append I am indebted to Dr. Edward Penny, of Marlborough. They describe a case of much interest:—

“ MARLBOROUGH COLLEGE,

“ *March* 12, 1899.

“ DEAR SIR,—Some years ago, when I was house physician at the Seamen's Hospital, Greenwich, you were, I remember, much interested in an unusual case of skin affection under my care, and remembering this I venture to write to you now to tell you of a case now under my care which must, I think, be of very unusual occurrence.

“ A boy in this school (nearly 15 years old) was taken ill ten days ago with what appeared to be a moderate attack of influenza—headache; temperature between 100 and 102°. A week ago the temperature (which had shown signs of falling on the previous day) began to rise higher, and late in the evening he felt his mouth sore. I found on the soft palate two or three ‘blebs’ containing amber-coloured fluid. He had a restless night, and on the following morning his temperature was 104°, and blebs had appeared over nearly the whole mucous membrane of the mouth, as well as the fauces and throat so far as visible. Within the next few days the nose, the glans penis, and the mucous membrane of the eyelids, and apparently, I think, also the conjunctiva, were affected; while blebs containing a slightly milky fluid, and standing on slightly raised inflamed bases, appeared on the hands and feet (especially round the matrix of each nail) and to a less extent on the arms and legs, while some half-dozen appeared on the back of the thumb. The last ‘crop’ of spots was on the two thighs two days ago.

“ The condition of the boy has been very distressing; the mouth, throat, and nose being so affected as to render nutrition difficult and sleep rare. Now the mouth is fairly clean and the general condition rather better. During the week the temperature has ranged between about 101° and 102° or even 103°, the pulse between 90 and 110.

“ Sir W. Broadbent happened to be in this neighbourhood on Wednesday, and he saw him and pronounced it ‘pemphigus.’

"It seems that two years ago the boy had a similar, but less severe attack, following recovery from influenza.

"Thinking you might like to hear of the case, I venture to send this.

"I am, yours faithfully,

"EDWARD PENNY."

"THE HERMITAGE, MARLBOROUGH, WILTS,

"April 12, 1899.

"MY DEAR SIR,—There was no further development of the 'pemphigus' after I wrote to you, but the boy's condition only very gradually improved until March 29th, when he was put into an invalid-carriage and taken to his home in Hampshire. I have since heard that he still gradually improves, but has not yet had his clothes on.

"Up to the time he left here there was present a considerable amount of 'congestion' of lung on both sides; the temperature remained between about 100° and 101°, and the pulse was always over 100, often 110 and sometimes 120 in the minute. I believe I am correct in saying that during the first ten days of his illness (after the eruption appeared) the boy did not sleep one minute at a time night or day, so constant and distressing was the cough which seemed to arise from the state of fauces and throat and nose. The mouth was very slow in 'cleaning,' and even when he left, the tongue and lips were still sore. When he was able to take nourishment in more than minute doses, he complained that pain accompanied the swallowing of food down the gullet and into the stomach.

"For treatment he took Liq. Arsenicalis, beginning with half-minim doses three times daily, and increasing until when he left he was taking 7 minims three times daily. The opium, which I remember you also advised, I feared to use in his congested state of lungs (but I daresay I was wrong in this). All the pemphigus on the skin healed readily and left no sore places. The prepuce was so sore that I feared adhesions might occur, but this also became quite healed.

"I imagine that it is difficult to know how much of this long illness may be due to the influenza, which I feel no doubt he had to start with.

"Believe me, yours very truly,

"EDWARD PENNY."

In a subsequent letter, Dr. Penny informed me that he had heard from the boy's father that he had quite recovered, and was likely soon to return to school.

NOTES ON SYMPTOMS.

(Continued from page 182.)

No. LXII.—*Pupil and Bladder Symptoms in the early stages of Tabes.*

An example of a somewhat exceptional condition of the pupils in an early stage of tabes came under my notice in the person of A. N——. This gentleman had been treated for syphilis, in Vienna, by inunction, five years before I saw him, and required occasional return to specifics ever since. Finally he began to experience difficulty in micturition, liability to “neuralgic pains” in his lower limbs and scalp, and his pupils had been observed to be dilated. Both pupils were larger than normal, but the right was conspicuously dilated, and in neither of them could any motion be observed on direct exposure to light. The left contracted a little in the act of accommodation, but the right was motionless under all circumstances. Accommodation was still perfect with perhaps a very slight defect in the right eye. He could read small print at twelve inches with either, but complained that all objects were a little blurred when the right eye was open, the blurring being removed by a low convex glass. With this form of iridoplegia the chief concomitant was failure of expulsion-force in the bladder. This had been so troublesome that he had submitted to have an instrument passed in the belief that he had stricture, and with the resulting verdict that his stricture was spasmodic only. I, however, passed a large flexible bougie, and found no impediment whatever. Mr. N——’s description of his micturition was that he voided his urine in a very small

and feeble stream, and often had to wait a while, once or twice, to recover force before he succeeded in emptying the bladder. He had experienced no material difficulty in defecation. He could still walk twenty miles at a stretch, and could walk quite well with his eyes shut. This last fact fitted with the circumstance that he had good knee-reflexes, if anything excessive. He acknowledged that he had very little sexual appetite, but this had never at any period of life been great. The pains which he described had been of an explosive character, and felt in certain definite parts of the lower limbs, the great toe, the calf, and lower part of thigh. They were of momentary duration, but would recur over and over again for half an hour together.

Taking together the pupil symptoms and those of the bladder, I could feel no hesitation in the diagnosis of tabes, and that they were of directly syphilitic causation was made probable not alone by the history but by the presence of a large unhealthy ulcer in the posterior pharynx. It must be noted, however, that there were no indications whatever of locomotor ataxy.

No. LXIII.—*On minor forms of Xerostomia.*

I have not of late years seen any fresh examples of xerostomia in a pronounced form. I am inclined, however, to suspect that in minor and ill-characterised forms it is not very uncommon. In two cases recently complaint has been made of "dry mouth," and in both there was certainly a deficit of moist secretion, although it could not be asserted that it was absent. Both patients were, as usual, women, and past middle age. In one, aged 60, the patient had experienced a threatening of apoplexy. The symptom which justifies the diagnosis of defective salivary secretion is the necessity to continue sipping fluids whilst eating. When this necessity is alleged, and it is proved that food fails to provoke a flow of saliva, we may safely assume that something is wrong in the reflexes of the glands concerned.

It has often struck me that we may perhaps infer from what is so easily observed in the case of the salivary glands

as to what may not improbably be possible in that of such glands as the pancreas and even the liver itself. We know how easily certain kinds of emotion may cause the mouth to become dry and the salivary glands to cease their secretion for a time. We know also that in some persons this arrest of secretion may be permanent, and that probably in many more a partial arrest may become more or less habitual to the individual. If similar occurrences are possible to the liver, we have an easy explanation of the phenomena of certain forms of bilious disturbance whether with or without jaundice.

No. LXIV.—*Death of Charles VIII. (of France)—Symptoms those of Brain-Compression after Rupture of Middle Meningeal Artery, and importance of the Interval as a Symptom.*

There is no difficulty in assigning the cause of the death of Charles VIII. of France. It is related that, wishing to view some sports which were going on in the palace yard, he hurried with his Queen through a dark and unfrequented passage. In doing this he struck his head with great violence against the top of a low doorway. Although somewhat stunned at the time, he went on to see the sports and sat for half an hour conversing with those about him. He then complained of his head, and soon became unconscious. After this he several times attempted to speak, but relapsed and finally died, about nine hours after the seizure, on a couch which had been prepared for him on the spot. It was supposed that he had had a fit, but no surgeon can doubt that his death was due to a linear fracture of the skull, with rupture of the middle meningeal artery, and ultimate extravasation of blood between the dura mater and bone.

It is well known that in many of these cases an interval occurs between the blow and the occurrence of the extravasation, and that during this interval the head symptoms may be quite absent. Our surgical records abound in such cases, and several from my own practice at the London Hospital

were recorded in my Astley-Cooper Prize Essay on the Injuries to the Head. The one which forms the closest parallel to King Charles's case was one in which I never myself saw the patient, but of which the full details were communicated to me.

A young lady visiting Carisbrooke Castle fell from a little height (only a few feet) and struck her head against a stone. Although stunned at first, she quickly recovered, walked home, and sat down to table with her family, assuring them that she was not really hurt. During the meal, however, she suddenly complained of pain in her head, and rose to go to her bedroom. She was, however, unable to get upstairs without assistance, and soon afterwards became unconscious, death occurring within a few hours.

The explanation of the interval is no doubt that the torn artery does not give way at once, but waits until the circulation is fully established. In some cases there are several intervals, apparently owing to temporary arrests of the bleeding. It is very probable that the artery is not in most cases torn completely through, nor the dura much detached. Similar delays and arrests in the bleeding from injured arteries are not unfrequently seen in wounds of the palm and of other parts.

No. LXV.—*Giantism and Acromegaly.*

I have just seen a man whose condition is perhaps one intermediate between giantism and acromegaly. His hands were enormous, their digits long and very broad. They were as large as in the average cases of acromegaly. His height was six feet two inches. He was well-proportioned, and there was no unusual projection of his chin. His head was large, and showed some tendency to projection at its sides, but on the whole he was well-proportioned. He had very large lunulæ, and was of dark complexion suggestive of Semitic descent. Of this, however, there was no proof. He was a native of Devonshire, forty-six years of age. He had lost most of his teeth by early caries, and wore false ones. He had enjoyed good health, his only remembered illness

having been an attack of pneumonia. He said that he felt certain that there had been no increase in the size of his hands or head since he attained adult age. He had been a warder in a prison, and said that he had never had any trouble with his guests, since the sight of him and a little persuasion had always sufficed.

No. LXVI.—*Cystic Formations in the External Ear, and their value as indications of Ear-pulling.*

The formation of cysts in the upper half of the external ear, with induration and swelling of the whole structure, was remarkably illustrated in the case of Mr. C. I——, a gentleman of 60, who consulted me on account of cancer of the tongue. The ears were so conspicuously enlarged that I could not help taking notice of them. His explanation of their condition was ready. He had never been insane, and although distinctly of nervous organisation he would not admit that he had any tendency in that direction. The disease in his ears was caused, he said, by a habit which he had acquired of always pulling them about when engaged in thought. In proof that he had subjected them to much manipulation, he showed me that he could bend the ear forwards and put its rim under the antitragus so as to completely cover the inlet, and it would remain so. He added, "I never saw any one else who could do it." These cystic formations in the external ear have been observed chiefly in lunatics. One suggested explanation of this fact has been that they are caused by the attendants pulling the ears of their patients, that being the only form of punishment permitted them. My present case confirms the belief that they are due to repeated violence of this kind. Whilst in lunatics they are usually found in the uppermost part of the ear—that most likely to be pulled by another person—in Mr. I——, whose injuries were self-inflicted, the cysts were chiefly found in the middle of the ear. It is obvious that this part would be the most likely to be implicated in bendings forward of the ear by the fingers of its possessor. The right ear was more

severely affected than the other, probably because accessible to the left hand whilst the right was engaged in more important matters. Mr. I—— was a musician, and evidently a very restless man. I have never seen a worse example of this condition, and taking all the facts into consideration, I think we may hold it as proved that the state is always the result of violence and has no essential connection with insanity.

No. LXVII.—*White Bars crossing the Nails—All the fingers affected and all the toes exempt—History of attacks of Nervous Palpitation.*

An interesting case bearing upon the significance of transverse white markings in the substance of the finger-nails came under my notice in the person of a man named H——. He was 34 years of age, and had lived most of his life in Buenos Ayres. He had been for fifteen years the subject of common psoriasis, but the state of his nails had probably nothing whatever to do with that and had indeed been present long before any affection of his skin. He alleged that his nails had been marked as at present all his life, and he did not seem to have observed that the white marks were carried forward by the progress of their growth. His testimony that these marks never changed must be taken with some reservation, for he was not a very close observer. He alleged that neither season nor climate made any difference, and he could not associate the appearances with any disturbances of health. He was not liable to sick headaches, nor did he ever experience anything of the nature of rigors. His only suggestion was they came from attacks of nervousness. His hands were habitually cold, but when he felt nervous they became yet colder, and he was very prone on any excitement to experience a severe attack of palpitation of the heart with cold extremities. Such attacks might occur once in a fortnight or once a month. I have little doubt that he was correct in his suspicion, and that these attacks were really the occasions on which the nutrition of his nails was temporarily interfered with.

The state of the nails to which I refer consisted in the formation of white lines which crossed them transversely and of which there were four or five on every nail of both hands. Then the nails were striped like the markings on a zebra's coat. They were strong, thick nails, and well polished on their surfaces. The streaks of white opacity did not cause the slight unevenness. All the nails showed the same number of bars and at about the same level. Had the white markings been in spots instead of lines, and had they been irregularly placed, it might have been supposed that they were due to mechanical injury at the nail-fold. Such explanation was, however, out of the question in face of the facts that all the nails were alike and all the bars transverse and crossing the nails from side to side.

I inspected the toe-nails and found them quite free from markings.

No. LXVIII.—*Peripheral Opacities in the Lens not always indicative of progressive Cataract.*

A medical friend, whom I had not seen for nineteen years, called on me to ask me to examine his eyes. I found that with proper glasses for his presbyopia he could see well to read the smallest print, but nothing helped him to perfect distant vision, $\frac{2}{3}$ being all that he could see. He suggested cataract, and I accordingly took him to the ophthalmoscope-room. One pupil being widely dilated, I found in the periphery of the lens, all round, wedges of dense opacity projecting edgewise towards the centre, which latter was still clear. The conditions were alike in the two eyes. I told him, "You have peripheral cataracts, with perfectly clear central parts. It is a form which often progresses very slowly, and you need not for the present be anxious about losing your sight." "Those are precisely the expressions you used when you looked into my eyes nineteen years ago," he replied. Thus it would appear that the advance had been exceedingly slow; that there had been some, however, is probable, for my friend's reason for coming to me on the present occasion was his consciousness that he did

not see so well as formerly. He was sixty-seven years of age. It is of interest to add that I had recognised the same form of cataract in his father at the same age. In that case, however, death, a year or two later, prevented me having any opportunity for estimating the rate of progress.

I have published several cases in former times illustrating the same point, that lenticular opacities beginning in the periphery often advance with extreme slowness. In one case a woman brought me a pen-and-ink sketch made by Sir William Bowman fourteen years before, which showed that the wedges of opacity were then of almost exactly the same size that they still were.

No. LXIX.—*Case illustrating the non-significance of a fixed and dilated Pupil.*

An instance of unexplained and permanent dilatation of one pupil came under my notice thirty years ago, and I have again recently seen the same patient. The conditions are exactly as they were. The left pupil is widely dilated and fixed, but accommodation is not lost. The dilatation was first noticed by one of the patient's friends when he was about thirty years of age, and he then came to consult me about it. It entailed no inconvenience, and I could find nothing to explain it. The patient was in good health, and had received no injury. He remains in good health still, and no other symptoms of disorder of the nervous system have been developed. He is now sixty-six.

No. LXX.—*On the value of Psoriasis Palmaris as a Symptom.*

The form of psoriasis palmaris which occurs as a tertiary phenomenon in syphilis is very often, or indeed usually, of one hand only. It may be recognised also by its steadily aggressive edge and abrupt border. Outside its area the skin is perfectly healthy, and not either congested or desquamating. The area involved may be either round or crescentic. Peeling without any thickening and without

much tendency to the formation of crusts is the ordinary condition.

A very good example of this form was presented in the case of a Mr. R——, aged 50, whom I saw in April, 1899. I had treated him three years previously for a serpiginous sore on the skin of the penis, which was soon cured by iodoform and iodide of potassium. He had probably had syphilis twice, once at the age of 20, and again at the age of 36, and he had for years suffered from a bald and leucomatous tongue. He had lived very freely, but enjoyed excellent health. The patch in the palm for which Mr. R. came to me on April 4, 1899, was almost round, and involved nearly the whole palm, extending somewhat into the clefts of the fingers. It had been aggressive for eighteen months, and in spite of some treatment by iodides, &c. Its surface was red and excoriated, and at its borders was a ragged edge of thick and undermined epidermis.

It may be noted that in this case there had been no local cause of irritation, and also that the state of the palm and tongue were the only indications of remaining taint which the patient exhibited. I contented myself by trying local treatment only, giving him a chinosol lotion and ointment.

No. LXXI.—*Sense of Distention in the Rectum, present chiefly in the erect position, and persisting for many months.*

Dr. S——'s symptom, for which he has consulted me two or three times during the last year, is a feeling in the rectum of constant discomfort as if it were distended. Sometimes he says he feels as if he must pass flatus, at others it is a bearing-down sensation, "as if I had prolapsus." He is never in comfort excepting when in bed. In the recumbent position it passes off, and he can sleep well. In the morning it returns soon after the first action of the bowels, and continues the rest of the day. Walking relieves the sensation somewhat, and he tells me that he sometimes walks till he can stand no longer, but never quite loses the sensation. The relief of the bowels is regular every morn-

ing, and sometimes twice a day, but it does not take away the annoyance. Neither does the escape of flatus, which is frequent whenever he is alone.

Six months ago I recognised an isolated, somewhat pedunculated pile, but I told him that I did not think it caused his pain. He consulted a specialist, who thought differently and advised its removal. Dr. S—— was accordingly put under an anæsthetic and the pile was removed. At the same time a thorough examination of the bowel was made, and nothing else was found. The discomfort returned as soon as Dr. S—— resumed the erect position after the operation, and has continued ever since just as it was before.

I have examined the rectum with the finger several times. There is very little enlargement of prostate, and none of the vesiculæ; no tenderness of any part, and nothing can be reached. The bowel is usually empty of flatus, and contains only small portions of fæces. On the last occasion I thought I could feel a hard mass high up, but so high that I could not be sure about it. The usual symptoms of malignant disease, mucus, blood, &c., have been wholly absent.

CANCER AND THE CANCEROUS PROCESS.

The Superficial form of Rodent Ulcer.

A case which illustrated the most superficial form of the rodent ulcer which I have ever seen came before us at one of my Demonstrations on March 8, 1899. The patient was a man named R——, aged 53, who was sent to us by Dr. E. A. Féré. There was a long elliptical scar on the right lower eyelid. It was not conspicuous, but very definite when looked for. At its margins was a low roll of induration not thicker than a sewing needle, but at most parts quite definite. There was no ulceration whatever, the scar being quite sound, but I was told that at times a thin crust would form, on detachment of which a little discharge would be seen. This occurred, however, only at points. The history was of slow aggression during more than eight years, and that the border was advancing slowly in all directions. In commenting upon the case, I drew attention to its apparent insignificance and real importance, and mentioned one in which the early stages of the disease were quite as superficial and as slow in their advance, but in which finally ulceration had destroyed the greater part of the face. I suggested the free and repeated use of Pacquelin's cautery. By the side of the patient I showed one of Mr. Cæsar Hawkins' plates, in which the scar was far larger, whilst the advancing border was scarcely more definite.

In speaking of this as one of the most superficial which I have seen, it is to be understood that I mean in reference to its duration. In the very earliest stages of rodent cancer, in a great many cases the roll of induration is very superficial, and needs careful inspection in order to detect it. In many of these the nature of the disease is wholly overlooked, and

in some there may even be doubts as to the diagnosis. Whenever, however, anything of the nature of a definite rolled edge can be identified which leaves behind it a scar, however slightly marked, there the disease should be recognised, and adequate treatment promptly adopted. It is in this stage that the new growth may be completely eradicated without any severe measures. I greatly prefer caustics to either scraping or excision, and am accustomed to use fuming nitric acid in slight cases where there is no appreciable thickening, and Pacquelin's cautery in the more severe ones. By the expression "rolled edge," I mean an elevated, somewhat waved border, quite smooth and not undermined, which is easily recognised by those who have once seen it. It is usually free from inflammation and from papillary growth. It cannot be asserted that it is absolutely characteristic of rodent cancer. No case of rodent is, however, without it, and although syphilitic and some other forms of ulceration may sometimes simulate it, the simulation is not usually very close, and there are almost always other features, such as inflammatory swelling and undermining, which will help the diagnosis. If the rolled border runs evenly round the sore or scar—that is, without sinuities—some doubt should be entertained. The true rolled border of rodent is always somewhat sinuous, in the sense that it is made up of a number of crescents joining at their angles. This kind of border is shown in all good portraits of the rodent ulcer. It is present also in Paget's ulcer, which may be regarded, however, as being a form of rodent, and has for the most part the same freedom from liability to the infection of the lymphatic glands. It is not present in the crateriform ulcer, and is only ill-marked in certain forms of rodent attended with great thickening. It is in the more superficial forms that it attains its chief value as a means of diagnosis.

Papillomatosis Senilis at an early age, with important facts as to family history.

Mrs. A——'s family history affords an interesting illustration of the two forms of papillomatosis senilis, one in the daughter and the other in the mother, and both in

association with cancer in the grandmother. The two forms to which I refer are the pedunculated papillomatosis which occurs on the neck, and the flat patched form which occurs on the trunk. Mrs. A—— herself, aged 38, and in excellent health, came to me on account of what she called “an eruption of dark patches” on her shoulders and sides of abdomen. They had been first observed about two years ago near the navel, and had recently increased to an extent which made her very unhappy. She herself suggested that they were “a kind of wart.” I found the usual conditions; a crop of spots varying in size from a pin’s head to a large pea scattered over her shoulders, chest, and sides of abdomen, and made conspicuous by their almost black colour. All were a little raised and rough over their surfaces, but none in the least pedunculated nor even foliated. On my asking whether any relatives had them, Mrs. A—— told me that her mother had her neck “covered with warts of the kind which you tie off, but not in the least like mine.” She described exactly the condition which I have often seen on the necks of ladies, and which is mentioned in ARCHIVES, Vol. IX., p. 265. It was believed that there were no spots on the trunk in the mother’s case, but this must not be held to be proven. I carefully examined Mrs. A——’s neck and found only a single one. It was very small, and had a very slender pedicle. My next inquiry was as to cancer in the family, and the reply was that Mrs. A——’s maternal grandmother had died of cancer of the breast, at the age of eighty, after two operations. I could not elicit any facts as to the occurrence of the ordinary warts on the hands in youth in any relatives.

Mrs. A—— is, I think, the youngest person in whom I have seen this form of papillomatosis. Being only thirty-eight, she could not be regarded as “senile,” nor did she look so. She had enjoyed good health, and, as she said, had lived well. She had borne no children, but her menstruation was quite regular, and she showed no sign of approaching change of life.

The superficial form of Rodent Cancer—Rodent Cancer of Forehead and Scirrhus of Breast in the same patient.

I have mentioned at page 251 a remarkable example of the superficial form of rodent cancer. Since the page was in type a yet more curious illustration of this condition has come under my notice. In this case—of which an elderly lady is the subject—the whole of one half of the forehead looks much whiter than the other. On closer inspection it is seen that the whiteness is caused by a thin scar which occupies the whole region and is everywhere bounded by a low roll of aggressive growth. At some parts this advancing roll is not thicker than a knitting-needle, but at others it rises to that of a crow-quill. The whole side of the temple as well as the forehead is involved, and the thickest growth is that lowest down on the former. It is clear that the region of integument involved determines to some extent at least the depth of the cancerous invasion. It is chiefly on the forehead that these very superficial growths are seen. In the present instance the disease has been present many years, and no troublesome ulceration has ever occurred. The lady is now the subject of a withering scirrhus of the breast also.

THE NERVOUS SYSTEM.

No. CVI.—*Deafness, Iritis, and Facial Paralysis in the secondary stage of Syphilis—Subsequently Neuralgia and Loss of Speech—Good health six years later.*

All facts are of value which help us in the formation of rules for prognosis. In 1888 I attended a gentleman named P——, who, during the course of secondary syphilis had very severe iritis and at the same time inflammation of his auditory apparatus, resulting in facial paralysis and deafness. I have published his case as an example of what is very rare—implication of the trunk of the facial nerve at the same time as the loss of hearing—and in proof that the morbid changes are located in the bone and its coverings and not primarily in the nerves.* Under the liberal use of specifics my patient recovered from his iritis and regained the use of his facial muscles and the hearing in one ear. He has remained, however, absolutely deaf in the ear which was principally affected.

During the three years which followed his syphilis he had various relapses of nervous symptoms; very severe neuralgia and attacks during which he was unable either to speak or write were among them and caused some anxiety. So late as the end of 1891 he had recurrence of a dusky eruption on his abdomen. Specifics always removed his symptoms, but he did not remain long under care.

After an interval of six years, I have seen this patient again. He is now, and has been ever since his treatment, in good health, and he consults me now solely on account of

* See full report of case, ARCHIVES, Vol. V. p. 294.

rheumatic gout. He has experienced no relapse whatever of syphilitic symptoms. His pupils show extensive adhesions, but there has been no recurrence of iritis, and no trace of the facial paralysis remains. He hears well with one ear and not at all with the other. His present age is 57.

In explanation of the severe iritis, and possibly also of the inflammation of the ear, I may state that this patient, now himself the subject of rheumatic gout, is the son of a father who had true gout and of a mother who has her hands crippled with rheumatic gout. It is not improbable that this inheritance determined the incidence of inflammation of fibrous tissues during the febrile stage of secondary syphilis.

The fact that he has maintained such excellent health during the last six years is especially important in connection with the very threatening indications of affection of the nervous system from which he formerly suffered.

No. CVII.—*A study of symptoms in a case of threatened Paraplegia after Syphilis.*

A man aged 34, who consulted me a few months ago, gave me a detailed account of symptoms which had caused much difference of opinion amongst those whom he had previously seen. He had worked hard as a wheelwright and had formerly been a very strong man. He had been a total abstainer from stimulants, but in spite of this had been very excessive in sexual intercourse. During his twenty-ninth and thirtieth years he had been for sixteen months more or less regularly under treatment for syphilis. This did not, however, interfere much with his habits, and during the two years next following he had good health. In the beginning of the fifth year after his syphilis he found his lower extremities becoming numb and liable to tingle. Both feet were affected, but the left was the worse. He had at the time acute pain in his back. He did not lose muscular power, but the anæsthesia became almost complete. At this time the penis was so numb that although he had vigorous erections and could effect intercourse he experienced no sensation until ejaculation occurred. If in walking he made any false step, a tingling sensation passed up the limb and affected the

lower part of the abdomen and the opposite limb. At this time the advent of tabes was foretold by some physicians, but discredited by others. He was ordered iodides and also strychnia, but his final recovery occurred whilst taking mercury. What was really threatened was probably the paraplegia of transverse myelitis, but there was never any definite loss of muscular power. During the next year he thought himself well enough to marry, but a year later he came to consult me. His principal symptoms were an alleged inability to open his eyes on waking, and some weakness in his lower extremities. He appeared to be in good health and could walk well, but alleged that his legs soon tired. He had throughout kept at his work as a wheelwright, but alleged significantly, "I never now undertake piece work." He said that he was still very excessive in sexual intercourse, and had been so ever since his marriage.

I found the pupils small but active, and the knee reflexes good even to excess. He walked rather badly, as if weak in his back, and stooping somewhat. He could, however, walk just as well with his eyes shut.

My diagnosis was an incomplete transverse myelitis a little lower down than usual, and thus not implicating the centre for the sexual function. The supposed escape of the muscular system had probably not been so complete as was imagined, still its comparative exemption was very remarkable. The inability to lift the upper eyelids on waking was probably to be attributed to defective tone owing to excess in sexual intercourse. On this latter point I gave him very strong advice, assuring him that he had had a narrow escape of losing the use of legs, and might still do so if he did not take care.

No. CVIII.—*Study of Symptoms in a case of Syphilis of the Nervous System—Different parts affected simultaneously.*

In the case of Dr. S——, a nail-chancere was diagnosed in 1875. He took mercury, and had no secondaries. He subsequently married, and had a healthy family.

In December, 1895, he again had the misfortune to infect his finger, and had a troublesome chancre and eruption. In May of the following year he had a severe nervous illness, of which the following are the main facts. He became deaf, so much so that all conduction by the bones was lost, and it was necessary to shout to make him hear at all. At the same time he had ulcers under his tongue and some imperfection of sight. He was all the time under some treatment by specifics, but not perhaps sufficiently.

In November of the same year an attack of illness set in with vomiting and diarrhoea. He wasted away and tottered in his walking, and at length became unable to walk at all. He had also diplopia and nystagmus, and his lower limbs were liable to jerk. There was a hyperæsthetic belt round the lower chest, and some loss of power in bladder. He was confined to bed two months, but was never quite disabled from rising to the night-stool. It was feared that he would not recover, and one of his most urgent symptoms was vomiting.

It is clear that such a case as this can neither be placed under the head of paraplegia nor of intracranial syphilis. Many parts of the nervous system were affected at the same time. We have the symmetrical deafness which proved curable, the temporary diplopia, the troublesome vomiting, and the loss of power without anæsthesia in the lower extremities. Finally, we have the nearly complete recovery under the vigorous use of specifics. There can be little doubt that the illness was a consequence of the second and recent infection, and not of the one twenty years previously. The recent occurrence of a general eruption and the existence of lupoid patches even after cure of the cerebro-spinal illness are conclusive on this point.

The supposition that different parts of the nervous system were attacked by a form of neuritis almost simultaneously is, I think, the only hypothesis which will explain the course taken by the symptoms. The lesson as to therapeutics is, I think, definite. The patient's state of debility and cachexia led his advisers, as those conditions have led many others, to suspect that mercury had already been pushed too far, and

to insist upon its suspension. What was really wanted was its more vigorous employment.

During the early part of this severe illness his medical advisers did not prescribe specifics, believing that he had already taken them too freely. When, however, they were resumed and pushed he rapidly improved. During six weeks he took three drachms of iodide of potassium a day.

I did not myself see Dr. S—— during this severe illness, which occurred in South America. He subsequently came to England and saw several consultants, myself among the rest. He was able to walk fairly well, but not more than half a mile or so, and had quite regained his hearing. His knee reflexes were normal, and his optic discs showed nothing amiss. The only existing evidences of syphilis were a lupoid patch on the forehead and another on the scrotum. His head was clear and free from pain. A six weeks treatment sufficed to cure the lupoid sores, and Mr. S—— was then quite well, though weak in his lower extremities and not able to walk far. It was now nearly two years from the date of contagion, and he was able to resume his practice.

SYPHILIS.

No. XCII.—*Periostitis of Bones near the Elbow-joint in an infant—Hereditary Syphilis.*

In March, 1869, an infant of about eight months was brought to me at the London Hospital on account of a swelling above the left elbow. It was suspected that the bone had been fractured. I found, on careful handling, the lower part of the humerus decidedly thickened, the enlargement being just above the joint. The upper part of the ulna was also somewhat thickened, and possibly the radius also. The history of injury was indefinite. The child seemed to be in good health. I expressed to Mr. Wyles, who brought the child to me, my belief that the enlargement was not due to fracture but to syphilitic periostitis, the fact that at least two bones were involved being my chief reason for this opinion. I had also obtained from the mother a history of suspicious symptoms in other children. We decided to give iodide of potassium.

A month later I was informed by Dr. Ryegate that he had since seen this child and had heard of my diagnosis, which he confirmed by stating that he had attended the mother in her two preceding confinements, and that in each instance the infant had suffered from syphilis. Our patient with nodes had, however, not shown any other symptoms.

It may be convenient here to ask attention to a few facts in the clinical history of the chronic forms of periostitis and osteitis which occur in connection with inherited taint.

1. They occur usually in children from five to ten years of age.
2. The tibia, the fibula, and the ulna are the bones most usually affected.
3. They lead to great thickening of the affected bone, and not very unfrequently to necrosis of a thick superficial fragment.

4. They are attended by severe aching in the affected bone.

5. Differing from what we observe in the tertiary periostitis of acquired syphilis there is a distinct tendency to spontaneous cessation, and after lasting it may be a year or two, the disease comes to a close. After it has once ceased there is no tendency to relapse.

6. Although the tibia is the bone the most frequently affected, the disease may affect any part of the osseous system. A good illustration of it in the bones of the upper extremity is given in my Atlas of Clinical Illustrations.

7. As I long ago showed, it may cause overgrowth, and the bone is not only increased in thickness but in length. With this increase in length bending of the bone may be associated. In former days these bent tibiæ were confused with rickets and treated at our orthopædic hospitals with splints, to the great discomfort of the patient.

8. When both lower extremities are affected, a condition closely resembling osteitis deformans is sometimes produced.

9. The cases referred to in the above propositions are those of the tertiary stage of the disease. During the secondary period—that is, during the first year of life—more acute forms of periostitis may occur, and may lead quickly to suppuration.

10. In the early infantile period the bones of the skull are prone to suffer, and diffused encrustations may result ("Parrot's bosses.")

11. In the early period the parts near to joints more frequently suffer than the shafts of long bones.

12. The tendency to periostitis in the early or secondary stage is always transitory. In this respect it corresponds with the rare forms of periostitis sometimes encountered in the secondary stage of acquired syphilis.

No. XCIII.—*Herpes on Site of a Chancre on Skin of Penis and simultaneously on one Tonsil and in the Urethra, one year after Syphilis.*

All facts bearing upon the relation of herpes to syphilis

are of value. In the case of Mr. R—— I had prescribed for primary syphilis in April of 1898, and with such success that he had no secondary symptoms whatever. The sore was in the skin of the penis, and was definitely indurated. He had also hard glands in the groin. He was slightly salivated more than once, and at times left off his pills. With intermissions between, he continued them until he came to me a second time rather more than a year after his first visit. He had in the interval been under the observation of his family surgeon.

His second visit was on May 5, 1899, and the reason for it was that another sore had appeared on the site of the original one. He described a group of little spots on the skin of the penis which in the course of a few days broke and formed an irregular crescentic ulceration, about the base of which there was some oedema and slight induration. There was at the same time some soreness in the urethra, and micturition was attended by smarting. Exactly at the same date that the sores appeared on the skin of the penis and the irritation in the urethra, his throat also became sore. It was about nine days before I saw him that these three symptoms appeared together. I found his right tonsil and adjacent pillars of fauces swollen and covered with discrete small ulcers. These ulcers were made conspicuous by white secretion on their surface, and they were arranged in lines exactly like those of herpes. There was no trace of inflammation on the other side of the throat. The sore on the penis was on its right side, and so also the tonsilitis.

I could make no doubt that both were herpetic in their nature, and it seemed a fair inference that there were herpetic vesicles in the urethra also. No definite rigor had preceded the outbreak, but Mr. R—— stated that he had not of late been feeling quite well. He had no other symptoms of syphilis.

The suggestion occurred that the onesidedness and same-sidedness of the phenomena had probably alike their explanation in some influence brought to bear through the nervous system.

No. XCIV.—*Case illustrating Prognosis in severe Syphilis, followed early by Tertiary Symptoms.*

The following case is, I think, worthy of record as an example of severe syphilis with relapses during the first six years, resulting in cure, and followed by a long period of good health. It is not, however, offered as an instance of what is rare, but of what is common. We may also note that the patient married (with my permission) in the fourth year of his disease, and that, although he himself had nodes afterwards, neither his wife nor children suffered. Four children were born to them, and none ever showed symptoms. There were no miscarriages, nor did any die in infancy. All four are living and in good health at the present time. It is often supposed that bone disease is one of the most serious in the course of tertiary syphilis, and undoubtedly in many cases there is a strong tendency to relapse. In the present instance, however, the patient had nodes on his skull and tibiæ in 1877, was cured by iodides, and experienced no relapse whatever. He never again needed the iodides. When seen twenty-two years later there was a scar and a depression on his skull, but these were all that remained. During these twenty-two years, indeed, the patient had no indication whatever of persisting taint. His tongue, it is true, had become bald, and was slowly taking on the condition of white-paint sclerosis, but was not sore, and never showed any approach to gummatous infiltration. The sclerosis was no doubt in the main due to his persistence in the habit of smoking. Finally, in the twenty-second year, after the last manifestation of tertiary disease, a cancerous ulcer formed in one side of the tongue, due, as he supposed, and probably correctly, to the local irritation of a broken tooth. It was due also, no doubt, in part to inherited tendency, for one of his sisters had died after three operations for cancer of the same part. A brother also was believed to have had internal cancer. The appended schedule will give a good bird's-eye view of the facts :—

DATE.	AGE.	DETAILS.
1871	25	Syphilis, severely. Early treatment neglected.
1872	26	Under continuous treatment.
1873	27	Came to me with ulcers on legs and sores on tongue.
1874	28	I allowed marriage.
1875	29	Married.
1876	30	His first-born, a boy, never ailed anything.
1877	31	Came to me with nodes on the skull and tibiae. Iodides given.
1878	32	Taking iodides for nodes.
1879	33	Excellent health, but liable to sore tongue, and with gradually increasing sclerosis of the dorsum. No treatment for syphilis. No return of periostitis. Wife and four children all healthy. An habitual, but not an excessive smoker.
1880	34	
1881	35	
1882	36	
1883	37	
1884	38	
1885	39	
1886	40	
1887	41	
1888	42	
1889	43	
1890	44	
1891	45	
1892	46	
1893	47	
1894	48	
1895	49	
1896	50	
1897	51	
1898	52	His wife, who had never shown any suspicious symptoms, died of chronic phthisis.
1899	53	Comes to me with cancer of the tongue.

No. XCV.—*Was Ulrich Von Hutten the subject of Inherited Syphilis?*

Ulrich von Hutten, the humanist and reformer, wrote in 1519 "MORBUS GALLICUS." He had himself suffered from the disease for nine years, and, as he believed, it was inherited from his father. Daniel Turner (from whom I quote) admits that he had never seen the original work, but says that he had read "a piece of antiquity, being a translation thereof into good old English, about two hundred years past (almost contemporary with Hutten), by a Canon of Marten Abby, as he calls himself."

Von Hutten was born in 1488, and died at the age of thirty-five in 1523. Erasmus refused to visit him for fear of contracting his distempers. He would be thirty years of age when he wrote his book, and had himself led an immoral life. On the supposition that the disease came into Europe in 1493 it is of course impossible that he could have inherited it in 1488. Turner writes, "Our Knights Father was seized with this distemper soon after its arrival in Germany, and not being able to cut off the Intail, it came by way of Descent, or Inheritance, to the Son, who was miserably vexed therewith for nine years, as he there acquaints us, the malady showing itself in very painful ulcers, Knots like Bones (as he terms them) upon his legs and arms; stiff joints, rending night pains and filthy running sores, which had worn him away to Skin and Bones, and for which he had been as well cut as burnt, with Scissars Knife and Fire both actual and potential to no purpose; salivated six times as ineffectually; at last was cured by a strict diet for thirty days and upwards with a sudorific decoction of Guaiacum." Turner quotes the title of Hutten's work as "De Medicina Guaiaci vel de Morbo Gallico."

The description here given would fit perhaps better with acquired than inherited syphilis; indeed Turner himself proceeds, forgetting apparently about the "Intail," to suggest that from the narrative we may learn that the disease was at that time no mark of a dishonest conversation in the person infected, but might "spread its infection

in common converse or cohabitation." Von Hutten was during the nine years that he suffered between the ages of twenty and thirty, and nothing is less probable than that the symptoms he describes should at that period of life have been due to inherited taint. He may have accidentally contracted the disease from his father, and the latter may have acquired it soon after its arrival in Europe, but it is highly improbable that he inherited it. Thus there is nothing exceptional in the dates. In further corroboration of this view we have the published portrait of Von Hutten. A photographic reproduction of the original is before me. It represents a man with a high and narrow nose, and a physiognomy as far as possible removed from anything suggestive of inherited syphilis.

No. XCVI.—*A supposed example of Syphilis after Vaccination : not really such.*

It is now twenty-eight years since the two series of cases occurred which drew so much attention to the subject of vaccinal syphilis. About the same time several other isolated cases of undoubted character were recorded. Before these events, almost the entire British profession had been incredulous as to the possibility of transmitting syphilis by vaccination. Some series of cases, however few in number, but quite as conclusive, had been recorded on the Continent. These, supported as they were by our English experience, led to a prompt and universal acceptance of the belief that such transmission was a thing to be feared, and very probably to greatly increased precautions. It is now a matter of the deepest interest and a cause of great congratulation that, despite the vigilance of anti-vaccinators and their zeal in dragging such cases to the light, no considerable series of cases have since then been recorded. A few—a very few—isolated cases have undoubtedly occurred. The protracted inquiry of the Vaccination Commission did not discover more than three such, and in only one of these did more than a single infant suffer. At the same time, it exposed the fallacies which underlay the diagnosis in several

cases which had been certified as syphilis, but were not so.

In an earlier number of my ARCHIVES I published several examples of gangrenous inflammation of the skin around the vaccine pocks in which death had resulted, and in which there had been much difficulty in determining that the disease was not syphilis. In more than one of these some eruption had occurred, and in one there had been periostitis, yet the evidence seemed to make it almost certain that the illness was vaccinia, and not syphilis. I have recently published several other cases in demonstration of the difficulty of diagnosis between the eruptions due to vaccinia and those of syphilis.

The case which I have now to record adds another to the group to which I have referred. The arm inflamed, the vaccine sores coalesced and became surrounded by brawny induration. An eruption appeared, and the case was diagnosed as syphilis communicated by vaccination. Apparent benefit from mercury appeared to confirm this suspicion, but it is to be remarked that in spite of this benefit the infant died. The dates, however, as will be seen in the appended Schedule, are conclusively against the idea of vaccinal syphilis. In the latter the induration of the pock begins in the fourth week, and is usually limited, at any rate for a time, to the pocks infected. In this the inflammation began on the eleventh day, and the pocks were gangrenous on the fourteenth, and the eruption was out in the third week. Moreover, the lymph which had been used was calf lymph. It is very important that all such narratives should be carefully sifted, and they should not be permitted to stand on record to the prejudice of vaccination. It is on this account that I now record it.

An infant aged six weeks died in ——— Hospital seven weeks after vaccination, and the cause of its death was certified as “Vaccinal Syphilis. Marasmus.” The appended schedule displays the principal facts of the case :—

DATE.	WEEK.	DETAILS.
June 25		Born in a workhouse. Vaccinated from calf lymph on the sixth day (July 1st). A puny child.
July 2	First Week.	The vaccination at first appeared to be doing well. Entered as successful.
July 9	Second Week.	Left workhouse on 11th, the pocks being then inflamed. On thirteenth day the vesicles had coalesced, and there was gangrenous ulceration commencing.
July 16	Third Week.	A sore rash appeared on face, neck, and arm (mother's statement). On 22nd taken to ——— Hospital.
July 23	Fourth Week.	Mercury given. Increasing emaciation. Tripartite ulcer on arm, with hard edges and sloughing centre. Rash on head, neck, and arms, and to less extent on other parts.
July 31	Fifth Week.	Induration much less, and sore closing and looking more healthy. Child very feeble.
August 18	Sixth Week.	Sore healing. Death. No lesions whatever found at autopsy.

It was chiefly the presence of a rose rash, which persisted some days and became more or less macular and scaly, which led to the diagnosis of syphilis. This rash, however, made its appearance in the third week after vaccination, and it is therefore impossible that it should have been specific.

The induration of the base of the ulcer was also another feature which seemed to support the diagnosis. This induration was, however, well marked at the end of three weeks from the vaccination, and it involved all the pocks. It was probably only the brawny hardening which attends inflammation with sloughing.

The infant was one of twins. Both were vaccinated, but the boy, in whom the vaccination had shown nothing abnormal, died ("wasted away") four weeks later.

If it be suggested that probably the infants were the subjects of inherited taint, I can only reply that precisely similar occurrences have been noted in other cases in which this hypothesis was not sustained. In this instance no negative

facts are obtainable beyond the statement that neither of the two puny twins showed anything which was considered to indicate inherited taint.

No. XCVII.—*Syphilis in Australia—Case of Syphilis Maligna.*

“ 16, BOLTON STREET, NEWCASTLE, N.S.W.,
“ March 26, 1899.

“DEAR MR. HUTCHINSON,—I have mailed you this week a photograph of a case I had under treatment which may interest you. The subject was a Chilian marine engineer, a man who by the testimony of his ship-mates was a sober and chaste man until a certain day in December when he went ashore at Bombay and fell under the influence of alcohol. He copulated with a black prostitute *once* at the dockside. Between eight and ten weeks afterwards a single hard sore had developed. He could not exactly fix the date of its *first appearance*, and in two months ‘sores’ began to appear on his body.

“I saw him early in May when the ship arrived at this port, after a passage of 42 days from Bombay. He was then in a very emaciated condition, lying in his bunk helpless. The hard chancre was still on the penis—a ragged, ulcerated sore with a base as hard as sole-leather. Over the anterior part of the body was a rupial eruption, as you may see in the photograph. Some of the scabs had fallen off, but on the chest and face the scabs still remained. Except on the back of the neck and shoulder there were no sores on the posterior aspect of the trunk. The ship had no medicine chest, and the only treatment the man had was sulphur ointment, which was energetically applied. He had had no fresh food for at least a month. It is so seldom that one sees an untreated case of syphilis that I thought the photograph might interest even you.

“The patient was treated by mercurial inunction, the sores dressed with blackwash, and a plentiful supply of nourishing food given. After a month’s treatment he rejoined his ship—all the sores were healed and he had increased nearly two-stone in weight—and sailed for Valparaiso. I have not heard of him since.

“This is the only case of secondary rupia I have seen in Australia during eight years’ practice in a seaport town where ships arrive daily from all the ports of South America, Africa, and India and the East. The treatment of syphilis must have reached a very high pitch, or we are being, like the Portuguese, inoculated, for one rarely sees any tertiary syphilis, and the editor of the *Australian Medical Gazette* not long since was able to write that the secondary symptoms of syphilis were becoming every day very rare even in Australian hospital practice.

“I am, yours faithfully,

“ H. MARTIN DOYLE.”

THERAPEUTICS.

The Inhibitory Influence of Mercury as regards the development of Syphilis.

I have repeatedly asked attention to the very remarkable power which long courses of mercury appear to possess of preventing the development of the secondary eruptions of syphilis without wholly destroying the power of the poison. These facts seem to me to have a most important lesson for us as to the relations between the antidote and the virus. It would appear that mercury exercises a most definite inhibitory influence on the development of the latter. Scarcely a month passes but some new fact in illustration of this law comes under notice. The last which has done so is, I think, the most remarkable of all, and as such I now record it.

Major D——, aged 44, consulted me on December 12, 1896, for his first chancre, and he then had a mild secondary eruption, chiefly erythematous in character. I prescribed my usual pill of one grain of grey powder four or five times a day, and in a few weeks all traces of disease had vanished. He was now persuaded by a medical friend to take the pill only three times a day. In October, 1897, he had some bald streaks appear on the middle of his tongue, but no other symptoms.

Major D—— resided with his regiment in a distant town, and was under the supervision of another medical man. He continued my pill regularly for two years, but only three times a day. During this time he was in perfect health, and had no symptoms whatever, excepting the persisting streaks on his tongue.

On March 14, 1899, he came to me in great anxiety about

a general eruption which had appeared. It was a very conspicuous one of erythematous papules, some of them as large as shillings, and all attended by slight thickening, so that they were perceptible to the finger. The congestion in all gradually faded off at the margins. They were abundant on the chest and abdomen, and occurred to some extent on the upper arms and thighs. They did not itch, and he would not have known of their presence if he had not seen them when in his bath. They had appeared suddenly about a week before I saw him. There was no sore throat, no pains in bones, nor any other symptoms, but the two bald streaks on his tongue remained as before. On inquiry as to what he had been doing as to treatment, he assured me that he had taken the pill regularly for two years, and had only left it off about ten weeks before the eruption appeared.

The character of the eruption in this case made me feel certain that it was really syphilitic. It was not in the least like the cases of pityriasis rosea which so frequently cause difficulty in diagnosis. It had at the same time a character of its own, being of brighter tint and more uniform in character than is often seen in secondary syphilitic eruptions. There was no desquamation nor any threatening of pustules.

Cure of Lichen Planus by Antimony.

On April 10, 1893, at the suggestion of a medical friend, Mr. M——, a solicitor, aged 48, consulted me on account of what had been called "psoriasis." His history was that it had begun as a patch on the outer side of the right leg fourteen months ago. During the last three months the eruption had become generalised, and he was now covered with large groups of spots, many of which had coalesced into patches. Most of the spots were quite small, but they occurred over large areas. Most of them were smooth, and there had never been much desquamation. There were no spots in the cheek-pouches, nor any in the characteristically psoriasis positions. He had hitherto been treated for psoriasis, and had, I believe, taken arsenic.

My diagnosis was Lichen planus, and my prescription

tartarised antimony in small but increasing doses. On May 14th my notes record that the eruption was dying away from most parts, though it still persisted on the legs. The antimony had agreed well, and he said that he felt clearer in the head and brighter whilst taking it. The dose was now $\frac{1}{6}$ of a grain three times a day.

After this I did not see Mr. M—— again for six years. In March, 1899, he came to me for a wholly different matter, and told me that after his last visit his skin had soon got well, and that he had remained absolutely free ever since.

This case seems important, not only as illustrating the usefulness of antimony in the treatment of lichen planus, but as confirming previous statements as to the nature of that malady. I have often insisted upon the tendency to complete recovery as being one of the most important features which distinguishes it from psoriasis. The completeness of the disappearance of the eruption and the restoration of the skin to perfect health constitutes another very important characteristic. In psoriasis the cure is rarely complete, and the relapses are usually very prompt. In lichen planus, on the contrary, when cure once sets in, it is often rapidly accomplished, quite complete, and may last for many years. Sooner or later, however, a return of the malady does take place, and the second or third outbreak may be more severe than the first. We need, however, more information on this latter point than we as yet have in hand. Those who possess details as to cases of cured lichen planus which extend over many years would do well to place them on record. It is surely a clinical fact of great interest that an individual should be liable to a malady so definite several times in his life, with intervals of many years of absolute immunity. If the fact should be established beyond doubt, it would help us not only in our conjectures as to the true nature of the disease, but might possibly throw light also on certain other maladies which recur after long intervals. Our forefathers were believers in recurring crises in a man's life, and held that definite periods (seven years, for instance) sometimes marked the intervals between the recurrence of like bodily conditions.

Whilst on this topic I may just record that I have recently inquired of Mrs. Fletcher, whose case as an antimony cure of lichen planus I have already recorded, as to the completeness and permanence of her recovery, and have learnt that she is absolutely free from the eruption and in good health.

Amongst other maladies prone to recur after long intervals may perhaps be named melancholia, gout, certain forms of anæmia, and neurasthenia.

Coleridge's account of how the Opium-Habit was acquired.

The following has been often quoted, but it cannot be too widely known. It is an account in Coleridge's own words of how he was led into the fatal habit of using opium: "I wrote a few stanzas three-and-twenty years ago, soon after my eyes had been opened to the true nature of the habit into which I had been ignorantly deluded by the seeming magic effects of opium, in the sudden removal of a supposed rheumatic affection, attended with swellings in my knees, and palpitations of the heart, and pains all over me, by which I had been bed-ridden, for nearly six months. Unhappily, among my neighbour's and landlord's books were a large parcel of medical reviews and magazines. I had always a fondness (a common case, but most mischievous turn with reading men who are at all dyspeptic) for dabbling in medical writings; and in one of these I met a case, which I fancied very like my own, in which a cure had been effected by the Kendal Black Drop. In an evil hour I procured it; it worked miracles—the swellings disappeared, the pains vanished; I was all alive, and all around me being as ignorant as myself, nothing could exceed my triumph. I talked of nothing else, prescribed the newly discovered panacea for all complaints, and carried a bottle about with me, not to lose any opportunity of administering 'instant relief and speedy cure' to all complainers simple or gentle. Need I say that my own apparent convalescence was of no long continuance; but, what then?—the remedy was at hand and infallible. Alas! it is with a bitter smile, a laugh of gall and bitterness, that I recall this period of

unsuspecting delusion, and how I first became aware of the Maelstrom, the fatal whirlpool, to which I was drawing, just when the current was already beyond my strength to stem. The state of my mind is truly portrayed in the following effusion, for God knows from that moment I was the victim of pain and terror, nor had I at any time taken the flattering poison as a stimulus, or any craving after pleasurable sensations. I needed none ; and, oh ! with what unutterable sorrow did I read the ‘ Confessions of an Opium-eater,’ in which the writer, with morbid vanity, makes a boast of what was my misfortune, for he had been faithfully and with an agony of zeal warned off the gulf, and yet wilfully struck into the current ! Heaven be merciful to him ! ” (April, 1826.)

At another place Coleridge wrote : “ I have never loved evil for its own sake ; no ! nor ever sought pleasure for its own sake, but only as a means of escaping from pains that coiled around my mental powers, as a serpent around the body and wings of an eagle ! My sole sensuality was *not* to be in pain.” (Note from Pocket-book, “ The history of my own mind and my own improvement.” December 23, 1804.)

Chinosol in Pruriginous Eczema of the Aged.

An old gentleman of near eighty has been under my care, more or less, for a year on account of an obstinate pruriginous eczema. Tar applications had done him great good, but he was not quite cured. On July 9th last he expressed great satisfaction with what I had last ordered him, and he was, in fact, as nearly as possible rid of his enemy. On asking to see the prescription, I found that I had substituted chinosol for tar. The prescription was as follows, and he had used it from April 13th to July 9th. I advised him to continue. He was an inveterate scratcher.

Prescription, April 13th.—Dissolve ten grains of chinosol in a pint of hot water, and use freely as a wash for all affected parts. After bathing apply an ointment of twelve grains of chinosol in the ounce of lard.

EXTRACTS FROM MY DIARY.

May 18, 1899.—A man who was brought to the Polyclinic by Mr. Hitchens to-day offered a most remarkable example of acroteric dilatation of blood-vessels. He was the subject of albuminuria, but not obviously out of health. His face, hands, and feet were of a deep dusky red tint, but what was most remarkable was that his gums, the mucous membrane of his lips, and that of the palpebral conjunctiva were of a lobster red. Evidently the arterial capillaries were permanently dilated. The changes were very conspicuous. No very definite causation could be suggested. I doubt much whether anything in the state of his heart or connected with that of his kidneys had to do with it. His pulse presented no great peculiarity.

June 24.—My friend Dr. P—— tells me that he is liable to severe attacks of nervous headache (Qy. hepatic). The curious point is, that before the headache comes on his intellect is always peculiarly vigorous and bright. "I get a feeling as if I could do anything and think out anything, and then in the course of a few hours a headache is sure to follow." I have myself experienced something of the same kind. When in my younger days very liable to sick headaches, I always used to expect one when inclined to congratulate myself on feeling unusually well.

July 13.—Miss D. C——, a lady of 50, tells me amongst other things that twelve years ago she had "exophthalmic goitre." She is now quite well of it, and her eyes not in the least prominent. There is no reason to doubt the diagnosis, for she was under the care of a distinguished

physician and was seriously ill for two years. She describes the full neck, prominent eyes, pulsating carotids, and irritable temper very graphically. The whole illness lasted two or three years, and then all the symptoms disappeared, and she has never been threatened with relapse. She was residing at the seaside (Margate) when she recovered, and had done so for a year or more. This is the second instance of recovery from this malady which I have seen in the last fortnight. Long ago I asked attention to the remarkable fact that the symptoms of this malady always disappear if the patient survives, and that they do not, with very few exceptions, return. The condition is, perhaps we may say, never indefinitely protracted. It does not imply any aggressive changes in any part of the nervous system. In this feature it offers a noteworthy contrast with many other maladies, and might perhaps suitably rank as a typical representative of a natural group. Of this group, spontaneous subsidence and no tendency to recurrence should stand as distinguishing features.

July 17.—I have often mentioned as an instance of the family proclivity to new growths that I once saw in the same house, that of a surgeon, three relatives, who were at the same time suffering from malignant growths. One had a rodent ulcer, another scirrhus of the breast, and the third a fungating growth in the palm. They were the mother and uncle and a sister of my friend. To-day I have seen one of his daughters who has a rapidly growing epulis, probably myeloid sarcoma from the gum of her upper jaw. She is thirty years of age. I believe that several other instances of malignant new growths have occurred in the same family, and that no two have been of the same kind. We appear to have here a remarkable illustration of the law of transmutation in transmission. That which is inherited is probably a tissue proclivity which awaits in each instance the application of some local exciting cause. In the instance of the epulis the plate fixing a false tooth appears to have been that cause. Such facts afford no support to the theory of the parasitic nature of cancer.

June 10.—A gentleman who came to me in Oct., 1891, with the symptoms of tobacco amblyopia, and concerning whose eyes I noted "discs pale on their outer sides, very decidedly so," has called again to-day. On my advice he wholly abjured both spirits and tobacco. He has regained almost perfect sight, and during the eight years which have passed has used it very freely, reading much in trains, &c. He now comes on account of a musca before his left eye. I find, on using the ophthalmoscope, that the conditions formerly noted are still present, the outer portion of the disc being almost white and in strong contrast with the rest. He has very greatly improved in general health by his adoption of abstinent habits.

June 20.—I have recently made an observation respecting the so-called ringworm tongue which may, perhaps, be novel, and which may be important. A little girl of three who was visiting in my house was reported to be ailing. It was during hot weather, and she was supposed to have lost her appetite from the heat. On looking at her tongue I found it marked by very conspicuous crescents of "ringworm" all round its edge, and showing also, what is not very common, a patch of denudation the size of a sixpence far back on its dorsum. This latter patch as well as the marginal crescents was most abruptly defined, and as the rest of the surface showed a creamy fur, they were very conspicuous, being red and clean.

As the child was staying in my house I had opportunity for seeing her tongue every day. The patches extended with remarkable rapidity. Not only did the crescents at the margins advance backwards, but the circular patch on the dorsum came forwards until they almost met, and the greater part of the tongue-surface looked red and raw. There still remained, however, an irregular belt which kept its papillæ, and as these were covered with creamy fur this belt was very conspicuous. Chlorate of potash was given, and the slight febrile ailment from which the child was suffering passed away. The tongue now cleaned and the papillæ were renewed. Ten days after the beginning of

the attack the tongue showed nothing except narrow crescents at the margin.

I subsequently learned from the child's father that he had been aware of the existence of the ringworm crescents for long, but had not thought them important. He also said that the child was liable to temporary febrile illnesses such as I had observed, but he had never connected them with changes on the tongue.

The question suggested by the case is as to whether children who have ringworm tongues are liable to attacks of glossitis attended by fever. In this instance the temperatures never rose above a degree beyond normal. The illness consisted in loss of appetite, a single attack of vomiting, and slight general malaise. I may add that I think the case is conclusive against the idea that the ringworm tongue is indicative of inherited syphilis.* It is certain that neither parent had ever suffered from that disease, and an elder sister of the patient has always enjoyed good health and has nothing amiss with her tongue.

July 10.—A member of our own profession calls on me to show me his tongue. He has white patches arranged symmetrically on the sides of its surface. They are not patches of sclerosis, but exhibit the characters of those which I have described as accompanying lichen planus. He is not now the subject of any skin disease, but he tells me that he had some years ago an eruption which was probably lichen planus. At the same time the white patches on his tongue appeared. His skin got well, but not so his tongue. As the patches, although very conspicuous, give him no inconvenience, I have advised him to let them alone. My experience has been that in most cases they disappear. My patient smokes, and there is also a remote and somewhat doubtful history of syphilis. The patches are, however, not those of scleriosis, and although they may be influenced by smoking, I do not believe that they have anything to do with syphilis.

* On this point see ARCHIVES, Vol. VII. 60, VIII. 312; also Vol. IV. 156, and "Clinical Illustrations of Surgery," Plate 91, page 157 of Vol. II.

July 14.—Mr. Frederic Mackenzie has just brought me an elderly lady who has an ununited fracture of the neck of her right humerus. The accident was a fall on the elbow, and was treated in the usual manner with a prolonged rest. It is now nearly two years ago. The arm is very useful, and but little inconvenience is entailed. The deltoid muscle is but little wasted, and the roundness of the shoulder is well maintained. A skiagraph shows the upper end of the shaft of the bone passing abruptly into the head as if impacted. On moving it, however, it is at once found that there is no union between the two, and the shaft is freely movable on the head without causing any pain. The head comprises the tuberosities, and but little more. It presents downwards an overhanging lip which makes a large shallow cup for the upper end of shaft. The patient cannot lift her arm outwards to more than a right angle, but can rotate it easily and can carry her hand behind. On the whole, her use of the arm is better than that often seen in well-united fractures in this position, which are frequently attended by much stiffening. I do not remember to have ever seen an ununited fracture at the surgical neck of the humerus before.

It is of interest to note that twelve years ago I removed this patient's right breast for cancer. She now has a small nodule of recurred disease close to the upper angle of the scar. She is, however, in good health, and there does not appear to be any reason to connect her fracture or its result with her liability to cancer.

MISCELLANEOUS.

No. CCCXXXVI.—*Multiple Lipomata in Subcutaneous Tissue.*

The woodcut given opposite illustrates the condition of the arms in a woman named Harriet P—— and aged 59. She was the subject of multiple lipomata on the arms and thighs. They had been present for many years, perhaps even from youth, but had recently much increased. They were so numerous that they were almost confluent, and gave a curiously lumpy appearance to the whole surface. The woman complained that they had of late given her a good deal of pain at times. They were prone to ache at changes of weather.

We have had at our Demonstrations a good many examples of this well-known form of tumour in various degrees of multiplicity. In some instances only a few quite isolated lumps were present, and in others great numbers. In the present instance we had, I think, the greatest number I have ever seen. The cases should be grouped by the side of what is known as Molluscum fibrosum. Both are examples of inborn tendency to non-malignant tumour-growth, which is usually revealed at early adult age and goes on increasing through life. In neither is there any liability to lapse into worse forms of disease. In the one it is the gland system of the skin which is affected, and in the other the subcutaneous fat. In both we may safely assume that peculiarities of structure are present at birth, which give the proclivity and, indeed, constitute the foci for the new growths.

No. CCCXXXVII.—*A case in which Facial Paralysis
persisted through life.*

As a rule the facial paralysis which comes on suddenly, and which we attribute to cold or rheumatism, passes away completely after a short duration. It is extremely unusual to see cases in which it has proved persistent. One such has recently been under my notice in the person of a lady of about

thirty. This patient's face is conspicuously drawn to the right side, the left being lax and flabby. The condition attracted my attention, and at first I suspected hemiatrophy. Not having been consulted about it I felt a little delicacy in taking notice of it, but venturing to do so, I found that the condition was due to facial paralysis, which I was told had been left by an attack in childhood. The lady, who was intelligent and appeared to remember her facts clearly, told me that at the age of twelve she had an illness which began by several days' severe pain in all her limbs, and culminated in a day of twitching in the left side of face, quickly followed by complete paralysis of it. She was in bed a few days, but nothing else occurred. The pain ceased when the paralysis had become complete. Since then she had enjoyed good health, but her cheek had never recovered, and her face had been gradually drawn over to the other side.

I found that the paralysis was not absolute. She could move the cheek a little, could almost close her eyelids, and when she frowned the left temple was to some extent thrown into folds. The zygomatici appeared to be quite lost.

The account given of the general pain in limbs which preceded the neuritis of the facial nerve might be supposed to fit the hypothesis that the patient was suffering from rheumatism; on the other hand its short duration and rapid and complete subsidence raised in my mind a suspicion that the illness might have been one of the herpetic family. It is at any rate a history well worth keeping in mind when we speculate as to the real cause of "Bell's paralysis." The occurrence of twitching in the facial muscles for a day or two before their loss of function is one, I believe, which is quite usual in these cases.

No. CCCXXXVIII.—*Cases of one-sided Hypertrophy of the Mammary Gland in the Male.*

In a former number of ARCHIVES I published some examples of hypertrophy of the mammary gland in the male, and took occasion to remark upon the great rarity of it in the unilateral form. What I wrote has been the means

of procuring the following communication from Surgeon-Captain Duer, now residing at the General Hospital, Rangoon. It would appear not improbable that this aberration of development is more common in Eastern populations than in Europe. Mr. Duer has observed five within six months, all requiring removal. I have seen a very few slight forms, and neither during twenty-five years' experience on the surgical staff of the London Hospital, nor in private practice, have I ever seen a case requiring operation. One of the cases of which I published a portrait had a Hindoo for its subject.

"In all the cases the hypertrophied gland was removed, and on section presented the appearances of the mammary gland of a female. In all except the first the gland tissue was quite healthy. All the patients were natives of India residing in Rangoon, and the main reason for their coming to hospital appeared to be that the woman-like breast excited ridicule.

"CASE 1.—Pairay, Hindoo cooly, æt. 25. Hypertrophy of right mammary gland of 'one year's duration.' Left breast normal, but its nipple very large, like tip of little finger.

"CASE 2.—Salookhu, Hindoo ward-boy (General Hospital, Rangoon), æt. 25. Hypertrophy and tenderness of right mammary gland. He says fluid-like pus has lately discharged from nipple. 'Duration eight years' A small abscess cavity found in middle of breast.

"CASE 3.—Hoshla Bukhsh, a Mussulman syce, æt. 27. Hypertrophy of left mamma, three and a half years' duration. Size of small orange. Right mamma normal.

"CASE 4.—Achona, Hindoo cooly, æt. 20. Right mamma like that of a well-developed nulliparous young woman. Left mamma normal. (Duration not stated.)

"CASE 5.—Ramsawmy, a Madras cooly, æt. 45. Hypertrophy of left mamma of 'two years' duration.' Right mamma normal. The mamma after removal was between four and five inches in diameter and one inch in thickness. The nipple was quite small."

No. CCCXXXIX.—*Sequel to a case of Cheiro-Pompholyx.*

I wish to put on record the sequel to a case which I published some years ago (1894) as an example of Cheiro-pompholyx. It is that of a gentleman named V——, and now aged 38. This patient in 1894 attended one of my Demon-

strations to show the condition of his hands. After that, until April of the present year I did not see him again. In April he came with another attack, and told me that he had one regularly every spring; they had not, however, been severe, and had, as a rule, soon passed off. The present one, however, was severe. All the digits excepting the thumb were covered with vesications, but the little finger was less severely affected than the others. The right hand was not affected. Mr. V—— told me that his thumb always escaped, and the right hand never suffered excepting that towards the close of the attack a few small sago-grains would appear on the sides of the middle digits. Sometimes an abortive attack would occur in the autumn also. On inquiring as to premonitory symptoms, I was told that usually a tendency to slight shivering and especially to goose-skin creepiness of the skin preceded the inflammation of the fingers. He had always excellent health, and since his liability to these attacks had ceased to suffer from common catarrhs. On the present occasion he had been exposed to a draught, and had felt creepings as if cold water were running down his back for twenty-four hours before the fingers showed bullæ.

The dermatitis on the present occasion lasted five weeks, and towards its close Mr. V—— showed me some small sago-grains on the middle and ring fingers of his other hand. Thus, although in the main unilateral there was a definite tendency to symmetry ("delayed symmetry"). Mr. V—— was also liable to herpes on his prepuce. I advised him to take a year's course of arsenic. I had formerly for relief during the attacks prescribed antimony, but he had, I believe, never taken arsenic.

No. CCCXL.—*Sequel to a case of Neuro-catarrhal Eruption (Erythema multiforme).*

At page 302 of Vol. IX. I have recorded the case of the neuro-catarrhal eruption known as Erythema multiforme. The patient, a lady of thirty, has again come under my observation with another attack. Last spring she came to

me on May 2nd, and this year again on exactly the same day her malady again appeared. In the interval she has had three, one in June, one in November, and one in March. On this last occasion she attended for demonstration at the polyclinic. The eruption was most characteristic, and, as before, it affected the face and sides of neck, the backs of the hands, and the tips of the elbows.

In demonstrating the case I drew attention to the very exact bilateral symmetry, these being spot for spot in the sides of the neck and on the two elbows. We remarked also that the papules were in some parts very like the wheals of urticaria, being abruptly margined, elevated slightly in their middles, vividly congested towards their borders, and with a paler ring surrounding a red point in the very centre. This red point in some of them might easily have been mistaken for a puncture. The congestion could be discharged by pressure, but not very easily. On the face the papules were easily felt by the finger, being thickened and a little firm.

No. CCCXLI.—*Narrative of a case of Recurring Attacks of Erythematous Œdema of Eyelids.*

Dr. Herbert Cook, of Cardiff, has been good enough to send me the following narrative as an addition to the series of cases recorded in Vol. VII. :—

“ *February 21, 1899.*

“ DEAR MR. HUTCHINSON,—I send you these notes of a case of recurrent erythema, as they may possibly interest you.

“ Miss I——, æt. 31; seen February 21, 1899; fifth attack. Much rheumatism and gout in her family.

“ The first attack occurred about eighteen months ago and came on without warning; others have occurred at varying intervals, some in summer, some in winter; the last one was just before Christmas, 1898, when she had a slight cold. One attack came on while out bicycling, and the eyelids swelled so rapidly that she had to be led home. She thought she had been stung in the eye by an insect. All attacks begin in the same way, and in the right eye.

“ *Present attack.*—At 8.30 a.m. to-day, when about to get up, she felt tingling and smarting at inner canthus of right eye; a small swelling:

speedily formed there, and in about three-quarters of an hour's time both eyes were closed by swelling of the lids. The swelling was accompanied by redness and flushing of the skin, and stinging, burning sensations.

"When I saw her at 8.30 p.m. the attack was subsiding; the left eye could be opened a little, the right eye not at all. The lids were puffed up and œdematous as in acute nephritis, of a tawny pink colour, and there was some œdema over the eyebrows. On separating the lids it was seen that there was moderate chemosis and injection of the ocular conjunctiva. There were two or three small herpetic spots on the upper lip, and she had a slight tracheal catarrh, which had been present for two or three days. No rise of temperature. No pain in joints. No rash about trunk or limbs. The urine showed a deposit of pink urates.

"She states that the attacks subside in two or three days, leaving slight staining as of a faint bruise."

No. CCCXLII.—*Remarkable coincidence in the occurrence of three cases of Herpes Frontalis.*

We cannot recognise in the following narrative anything more than a remarkable coincidence. In former times we used to speculate as to whether herpes zoster was or not an indication of a febrile constitutional disorder allied to the exanthemata; and quite recently the assertion that it is attended by a more or less obvious generalised eruption has again drawn attention to that theory. The recent discovery that it is often caused by arsenic, seems, however, to have given a fairly conclusive negative to such an hypothesis. In the present instance it will be seen that in all three cases the herpes occurred on the forehead. Now, there is no reason to believe that herpes frontalis differs, excepting in site, from herpes zoster of the trunk. Had the three simultaneous cases been due to contagion, it is improbable in the highest degree that they would have all been frontal. Two of the three would probably have been in the more usual position. We must, therefore, regard the narrative simply as adding another to the numerous examples of extraordinary coincidences which we encounter in medical practice. As such we shall do well to allow it its due lesson in teaching us caution.

I am indebted for the narrative to Dr. G. Lycett Burd, of Shrewsbury.

“ In the autumn of 1893, G. S——, an old gentleman of about eighty-three, had a severe attack of shingles, affecting the left eyebrow and side of the head as far back as the occiput, but involving neither the conjunctiva nor the nose nor eyelid. There was only moderate pain for several weeks, but much scarring resulted. The recovery was complete, and not followed by any neuralgia of the scars.

“ While his attack was in progress, my wife, L. G. B., æt. 80, was seized with an exactly similar attack, involving the conjunctiva, eyebrow, forehead, and head on the left side. The pain was more severe (possibly due to the conjunctival lesion) and the scarring moderate. The nose was unaffected. Since the attack she has never been long free from neuralgia in the scars and much painful conjunctivitis, following any prolonged reading or fine work or ill-health from any cause. During her illness, a dressmaker, æt. about thirty-five, was attacked in precisely a similar manner, the same distribution of vesicles occurring on the same side of the head, involving conjunctiva and supra-orbital region even more severely, but not involving the nose. This patient was the worst of the three, and the subsequent neuralgia and conjunctivitis have been more frequent and more severe. No drugs—internal and external—have appeared to benefit either patient. The first patient died three or four years ago. None of the patients had been taking arsenic, nor was there anything in common except the fact of their being all my patients.

“ I have never happened to see shingles in this situation either before or since.”

No. CCCXLIII.—*Inflammation of the Parotids after injuries and operations.*

Inflammation of the parotid gland after injuries and operations is a well-recognised occurrence. In my experience it has, however, been exceedingly infrequent. In ARCHIVES, Vol. III. p. 99, I recorded a case in which it occurred during peritonitis consequent upon rupture of intestine in a football accident. In 1892, in the case of a lady for whom I had excised some subclavicular glands several years after excision of the breast, Mr. Nicholls, of Eastbourne, under whose care she was, reported an attack of parotitis which began on the fifth day after the operation. It was on the left side only, the operation having been on the right. On the second day it involved in swelling the whole side of the face, and was attended by much pain and inability to open the mouth. It was not attended by any higher temperature than 100°. On the fifth day it had much subsided, and on

the seventh the swelling had almost wholly gone. Throughout the wound had done well, and twelve days after the operation the patient was quite convalescent.

These two cases, and a third which I saw with the late Dr. Aveling after an operation the nature of which I have forgotten, are all that have remained in my memory as examples of parotitis secondary to injuries or operation wounds. An able paper on parotitis after abdominal lesions, with extensive quotation of cases, was published some years ago by Mr. Stephen Paget (see Transactions of Medical Society, 1887).

In the abdominal case above referred to the attack was symmetrical and exactly like mumps. It began on the fourth day after the accident, and was subsiding on the eighth. The case ended in death on the sixteenth, all traces of parotitis having disappeared.

No. CCCXLIV.—*Curious example of Word-blindness.*

An interesting example of partial inability to learn to read, or what has been called word-blindness, has been for some time under my observation. The patient is a young gentleman of 21, of great intelligence, upon whose education no expense has been spared. I put into his hand a page the first sentence of which chanced to be "The power of the Franks was eaten up by the civil war." After much puzzling, he read out, "The power of the Franks was—by the civil war," leaving a blank, but could make nothing of the words "eaten up." When I suggested them he said that he understood their meaning perfectly, but that he had not been able to read them out because he could not spell them. Anything that is told him he can understand, but in spite of great painstaking he cannot read to any profit.

In association with this defect he has complete paralysis in the right hand of the extensor secundi internodii pollicis. I have alluded to this case in a former note.

ARCHIVES OF SURGERY.

OCTOBER, 1899.

A CLINICAL STUDY OF DISEASES OF THE NAILS.

(Continued from page 231.)

My report in the last number concerned itself chiefly with affections of the nails occurring in association with psoriasis. I endeavoured to establish the statement that if a patient be liable to common psoriasis of the body, and the nails be affected, the condition would be definitely a desquamative inflammation of the nail-bed, causing loosening of the nail at its free edge and sides, with accumulation of epidermis beneath it, but for the most part no alteration of its proper structure. In some cases the loosened portion of nail breaks away leaving the anterior part of the nail-bed exposed, but in others the nail is simply undermined, these differences depending chiefly upon the original condition of the nails as regards thickness and strength.

Whilst seeking to establish these conditions as affording us the true type of psoriasis of the nail-bed, I was obliged to admit that many cases are complicated, and that disease of the surface of the nail producing pitting, roughness, &c., may often be seen in conjunction with them. It was a definite part of my argument that typical cases of psoriasis of the nail-bed are often met with without any concomitant disease of the skin, just as the latter is well known to be as

a rule unattended by any disease of the nails. When, however, the two are met with together, or when there is psoriasis of the nail-bed in one member of the family and psoriasis of the skin in another, then I believe the type of the nail-disease will always be found to be what I have described.

I have yet a few additional facts to record bearing upon this matter before passing to other but cognate departments of my subject.

The first of the cases which I have to add is one which I have seen since my previous report was printed. A married man, aged 40, was sent to me by Dr. Bridger, of Portland Place, with a typical condition of psoriasis of his nails. All his digits, both of hands and feet, were affected, with the exception of the ring finger on the right hand, which I was told had always remained free. The conditions were the same in all the nails. They were loosened from their beds at their free edges and sides, and an accumulation of grey epidermis made them look opaque. The patient, an intelligent and observant man, described graphically the different stages of his malady, and used almost precisely the same expressions that several others had done. (See more especially the case of Mr. F—— at page 209.) He said that the condition of his nails varied at different times, and that repeatedly they had been almost well. He had thought that they were usually worse in summer and better in cold weather, but this of late had not been very definite. When a relapse was about to occur there was usually a slight feeling of heat in the ends of the fingers. Some little opaque grey spots would then become visible through the transparent nail near its edge, but not quite close to it. These he found it absolutely necessary to open with his penknife passed under the nail. He was accustomed to scrape out the dry epidermis, as it caused irritation. Thus these spots became continuous, with part of the nail normally detached, and the loosening of the nail would extend through half its length. He said that there was very little sensation in the nail-bed, and he was accustomed to scrape off the epidermis with a penknife.

PLATE CLXXIV.

DISEASE OF THE NAILS OF ONE HAND ONLY IN A CHILD.

THIS Plate illustrates the case of Miss M. H——, a girl of five years old. Her case is recorded at page 157. Only one hand was affected. Although suspicion was entertained as to ring-worm, no fungus was demonstrated. There was a family history of skin disease, and the child herself was liable to something very like psoriasis. The nails had repeatedly fallen and been reproduced.

1. THOMPSON'S CLINICAL REGISTRATIONS

(1911-1912)

PLATE CLXXIV.

DA CAMP "THE NILES OF ONE LITTLE BOY"
A CHILD.

[illegible]

This patient had been under the observation of one or more specialists before I saw him, and he told me that an endeavour had been made to establish the idea of favus of the nail-bed, but that repeated microscopic examination had failed to detect any fungus. For me the conditions were typical of psoriasis. The patient had no trace of psoriasis on his elbows and knees, and had never had any; nor did he know of any history of skin-disease in his family. He had, however, from boyhood been troubled with dandruff on the head, attended with considerable epidermic exfoliation. He was in excellent health, but of gouty family. His nail-disease had commenced on the left great toe seven years ago, and had in the course of the year more or less involved all the nails at present affected.

Typical Psoriasis of the Nail-bed relapsing during seven years, and in association with a skin eruption allied to Psoriasis.

Mr. A——, at present date, September, 1899, has psoriasis of the nail-bed of the most characteristic description. He is Semitic, in good health, but has been for seven or eight years liable to skin eruptions on various parts. These come and go. He has been repeatedly under my observation, as the subjoined notes will show. The umbilicus, the cleft of nates, the palms, and especially the cleft between index and ears, are at present affected. In addition to these special locations there is a general eruption of small, slightly desquamating papules on sides of chest, back, abdomen, thighs, and upper arms. These papules are, many of them, much smaller than those of psoriasis punctata, and are more or less polished like lichen planus. His nails are loose at their free edges, some of them as far down as half-way; all are perfectly sound on their surfaces and over the lunular region.

On October 18, 1893, I prescribed, for recurring herpes, arsenic in seven-minim doses. I allowed him to marry in the following year, having treated him for syphilis in 1889. At the present date, and for many years past, he has been

quite free from all signs of syphilis. He has now two healthy children. I am not inclined to regard either his nail-disease or his eruption as being in any essential connection with his remote syphilis. They persist and relapse exactly as do maladies of the type of common psoriasis. He retains good health, has healthy children, and for many years has shown nothing which any one not informed as to his history would suspect of being syphilitic. It is right, however, to give his full history. It is displayed in the subjoined schedule, and those who regard everything as syphilitic which follows syphilis may wonder why I hesitate to regard Mr. A——'s present symptoms as of that nature. They are, however, I repeat, such as I have seen in other cases wholly without specific history.

YEAR. AGE.		DETAILS.
1889	27	November 17th: remains of chancre and eruptions. See <i>A</i> .
1890	28	Under my treatment he got rid of his symptoms.
1891	29	Well, but liable to herpes.
1892	30	Well. See <i>B</i> .
1893	31	Well. See <i>C</i> .
1894	32	Married. November: lichenoid eruption on chest. See <i>D</i> .
1895	33	A child born dead "breech presentation." See <i>E</i> .
1896	34	In good health. Still some lichen on abdomen and chest. See <i>F</i> .
1897	35	A healthy child born. Still liable to relapses.
1898	36	Good health, but still liable to eruption, and nails affected.
1899	37	Again came under care for nails and eruption (September).

A.—November 17, 1889. Mr. J. A——, ætat 28. Syphilitic sycosis on chin. Has been treated for syphilis by Mr. Shilleto. Chancre observed four months ago at the meatus; remains of it still present. A few scaly patches on neck, some threatening to become rupial.

Notes made on December 2nd and January 15, record that he got well under treatment.

B.—September 28, 1892. He was well, excepting some smoker's patches in his cheeks.

C.—October 18, 1893. He is liable to preputial herpes two or three times a year. He now has psoriasis of his finger-nails and some scattered pustules on thighs. Some small leucomata in cheeks.

D.—November 30, 1894. He has not had herpes in prepuce for a year, but now shows some lichenoid papules in groups and rings on the sides of chest. He says that he has had them before and they come once a year.

E.—August 13, 1895. He has, in spite of his medicine, a relapse of his lichen and of his nails.

The nails are in the psoriasis condition, loosened at their free borders with epidermic accumulations under them; some of them are painful and show the nail-bed congested on its anterior two-thirds.

With this he has a lichen eruption covering the right side of chest and abdomen, smooth-topped lichen papules in groups. Very few spots on left side of trunk. He has some patches of psoriasis palmaris which crack in palms and on finger-sides.

F.—January and March, 1896. He still has lichen spots on sides of chest, so like *tinea versicolor* that I searched for fungus, but in vain. He says that this eruption has been present "on and off" since 1893. He has taken mercury, but without benefit.

The Senile form of Psoriasis of Nail-bed.

I may add to the series of the cases of severe psoriasis of the nail-bed occurring in elderly people, mentioned at p. 204 *et seq.*, one of which I find a brief note in my daybook for May 22, 1873. The patient was a woman of sixty-four who had formerly suffered from palmar psoriasis; her nails had become opaque, fibrous, and fluted, and were loosened at their free edges and sides. The nail-bed was distinctly inflamed, and the ends of the digits were painful. Several of her fingers on both hands were affected, and one of her toes. One or two of her children had suffered from cracked hands. She was the subject of a mild form of acro-arthritis.

Psoriasis of the Nail-bed, with history of former Psoriasis of the Skin.

Colonel J——, aged 48, came to me in August, 1899, for psoriasis of the nails. It had begun two months before to affect nails of fingers, but one toe-nail had suffered for several years. He had had syphilis in 1874, but had long been quite well. The conditions were typical and symmetrical, but affected chiefly the left hand. He had first noticed that the nails were unusually brittle. He had formerly had common psoriasis on his legs.

Additional Notes respecting an example of severe Psoriasis of Nails.

I have some additional notes to record with respect to the case given at p. 208 of my last number. Its subject, a

woman aged 50, attended at the Polyclinic a second time on September 28th. Her first visit was in May. Dr. Guthrie Rankin, who had sent us the case, told me that under treatment with a chrysophanic ointment and the internal use of arsenic the patches of psoriasis on the skin had been for a time quite well, and the condition of the nails very much improved. She had recently been to the seaside, and a relapse had occurred. In the centres of the large areas on her legs and forearms which had been involved in psoriasis and were still somewhat stained, fresh scaly patches were just developing. In addition to these, which were located almost, but not quite, in the characteristic psoriasis positions, she had large patches on the soles of her feet, and one just commencing on the palm of the right hand. Her nails were still much undermined and many of them broken, those of the toes being extensively destroyed, and the proximal fragments tilted almost vertically by the accumulation of epidermis under them. The plantar psoriasis involved most of the toes to their tips; the ends of the toes and the nail-beds were much less inflamed than they had been on the former occasion. The patient, a very florid and robust woman, was in good health, though possibly the subject of some heart disease. It appeared that the influence of the sea-air had favoured a relapse of the psoriasis, though the latter was probably in the main due to her disuse of the remedies.

This case is very valuable as proof not only of the association of this form of nail-disease with common psoriasis of the skin, but further that both affections were amenable to the treatment for that disease. It further proves that there is a form of palmar and plantar dermatitis which is in direct association with common psoriasis and not with specific disease.

It further shows that in cases in which nail-disease and common psoriasis go together, the one may take long precedence of the other. Thus, in this instance, the patient had had her psoriasis patches on the arms and legs for several years (four or five), but the affection of the nails only for a few months.

A mixed form of Chronic Onychitis in a man who was the subject of Psoriasis—Family history.

In September of 1889, Dr. Peart, of North Shields, was good enough to send me an interesting example of disease of the nails. Our patient was a gentleman, aged 58, in good health, who had long been the subject of a scaling dermatitis affecting the palms and palmar aspects of fingers. He had also some patches on the fronts of the ankles and a few on the legs, and he said that they were liable sometimes to form painful cracks. I was told that his father had suffered from a similar condition of skin, and that his sister had what were called "very dry" hands. His skin generally was dry, but there was no definite xerodermia. He said that he had suffered from his skin at least sixteen years, but the affection of the nails was much more recent. His nails had become rough, fluted, and fibrous, a mixed condition between psoriasis and eczema.

When I saw this patient a second time, eight months later, after a long course of arsenic, his hands were very much better; but I then noted that he had a group of very small patches like psoriasis, but more lichenoid, in the middle of the back.

This case confirms the general statement that disease of the nails is apt to go with that form of skin-disease psoriasis-eczema, which affects more particularly the extremities and is apt to run in families.

CASES IN WHICH NAIL-DISEASE WAS IN ASSOCIATION
WITH ACRO-ARTHRITIS.

In the cases which are placed in this group the affection of the nails was probably secondary to inflammation of the last joint of the digit, with general implication of the whole finger-end. In several, however, the causation may have been complicated, and in several it may be supposed that the disease was really a psoriasis of nail-bed in an arthritic subject.

Case of Gouty Onychitis.

Mr. R. M——, aged 67, a florid, healthy looking man, consulted me on July 3, 1891. He had never been ill except for an attack of "inflammation" of the intestines. He was three weeks in bed, and suffered from pain and vomiting the whole time. There was no obstruction of the bowels. His father died of stone in the kidney, and was under the care of Aston Key and Bright, and his brother had true gout. He himself was accustomed to live well, taking champagne, claret, and port. His urine was clear, and on one occasion he had gout. For the past ten years he had suffered from chronic onychitis, and had not had much treatment except some years before under Dr. Tilbury Fox. The ring fingers of both hands were exempt, and there had never been any psoriasis of the skin. The disease began in the hands, and later attacked the feet. The nails of the toes were fibrous, yellow, and somewhat inflamed. They felt sore and painful, and I was told that at first they had suppurated. His finger-nails were undermined and opaque, and suggested psoriasis. There was decided congestion around the affected nails, both on the hands and feet, but especially on the feet. His fingers were swollen, and the skin was peeling over their whole surface, due, as he thought, to the irritation of a tar-wash he was using. Aconite, colchicum, and the liquor sodæ arseniatæ in five-minim doses were prescribed.

On August 5th his toes were also affected, but with the difference that the toe-nails had become swollen and soft. They were three times their natural thickness, opaque, and like sodden leather. The ends of the digits were thick and red. The toe-nail of the right great toe was about to come off.

Acro-arthritis with Onychitis—Gout and Phthisis.

Mr. W——, an unmarried man, aged 38, consulted me in October, 1891, for acro-arthritis with chronic onychitis of several digits, but not of all. The thumb and ring finger of

the right hand and the thumb and middle finger of the left, together with the great toes and the toes next to them, all suffered. The ends of the affected digits were expanded, and the terminal phalanges were displaced. The nails were fibrous and undermined. There was slight but barely perceptible widening of all the fingers. He had never suffered from chilblains.

He was of fairly healthy family, but had himself been delicate from childhood, and in 1882 Dr. Murray of Newcastle had sent him out to Australia because of chest delicacy. He was a house painter, and had once suffered from lead colic, with a blue line on the gums. This may possibly explain his gout. He had been accustomed to drink beer, and still continued its use. I considered that his case was a mixed one of gout and scrofula, with tendency to the thoracic form of acromegaly.

A remarkable case of Disease of the Nails occurring possibly in connection with Gout, but non-symmetrical.

Mr. B—, æt. 35, a florid man in excellent health, came under my notice in 1872, and consulted me on account of great thickening of the nail of his right forefinger. In this finger the disease had existed for six years, and it was just beginning in the thumb of the same hand. The great toe of his right foot was also affected. The nail of the forefinger, which had been so long diseased, was very much thickened in all parts, fibrous in structure, and rough on its surface; that of the thumb, which was in an early stage, showed only a number of whitish spots, apparently under the nail just at its root. When I saw him a year later the thumb-nail of the other hand was beginning to be affected, and both the great toe and the second toe of the right foot were much advanced. I now noticed a very peculiar feature which either was not present at first or had been overlooked. Near to the roots of the affected nails were found solid indurations of the cellular tissue. These were of considerable size, but ill-defined, and were, he said, at times very painful. They varied much as to the degree of inflammation. Mr. B—

had, on my recommendation, taken a course of arsenic, but with no good effect. Yet there seemed some reason to suspect that he inherited a "dartrous diathesis," for he told me that his father had suffered most of his life with some skin eruption, and that his sister had been under Mr. Startin's care for an incurable disease of the scalp. In his father some thickening of nails had recently occurred. There was also a history of hereditary gout. He stated that his right forefinger had for long been liable to the formation of little watery vesicles, "sago-grains," which did not occur on the others.

Fibrous thickening of all the Nails, with some pain and Acro-arthritis—History of Gout.

Mr. John F——, a married man, aged 30, in splendid health, consulted me in September, 1892, on account of general onychitis in a very severe form. All the toe and finger nails were broken, fibrous, and softened. They had been carefully cut, and did not half cover the surface. None of the nails had escaped, but at times some got quite well, and then relapsed. There was some pain and a little swelling in the last joints of the fingers, and aching occurred after taking any alcoholic drink. The disease had begun on one finger. It affected first the corners of the nails, which then loosened, disclosing the presence of "white stuff" under them. On the scalp was some pityriasis, if not psoriasis, and on the legs were some chronic patches of dry eczema, one patch being under the knee. Arsenic, however, had never been taken. The disease had persisted for eight years, but during the last two years had been worse. Mr. F—— was gouty, and two years previously had nearly died of peritonitis.

Nail-disease in association with Acro-arthritis.

An interesting example of disease of the nails in connection with acroteric dermatitis was afforded by the case of a Mr. B——, whom I saw once or twice in 1879. He was not aware of any history of gout or rheumatism in his

family, but he had himself been liable to some swelling of one knee and ankle. All the terminal joints of his digits were somewhat swollen and stiff, and the next joints were also slightly affected in some of the fingers. The ends of the digits were congested and slightly swollen, and he suffered from extreme irritation between his toes. His toes were somewhat red and tumid, and their nails were almost in the sycosis condition, with general inflammation of their sides. He was pale and somewhat out of health. In childhood he had suffered from eczema intertrigo, and at the age of twenty-eight he had been under the care of the late Mr. Startin on account of some eruption on the fingers and backs of hands, but at that time his nails were not affected. The disease of his finger-nails had been present about a year when he came to me. The disease had begun at the root of the nail, and had caused the nail-substance to break up and fall away in fragments. He said that his ring fingers had been those first attacked, but finally all excepting the little fingers had suffered. The nail of the little finger of his left hand was just beginning to be inflamed. On the feet the little toe and the ring toe were still free. He said that he had never suffered from chilblains, but he had been liable to have his fingers die if he put them in cold water.

In this case I prescribed full doses of arsenic, but I saw the patient only during two or three months, and my latest note does not record any great improvement. He still complained that the last joints of his fingers were stiff and painful; the lobules of his ears were also congested. He had for some eight or ten months suffered from a tender spot in the spine, as if he had been struck by a stick, and complained much that his extremities were liable to go to sleep and become numb, but without any sensation of "pins and needles."

Case of Last-joint Arthritis with Disease of Nails—Both hands affected, but left the worse—Toes also slightly.

The notes of the following case are printed as they were taken at the Blackfriars Hospital for Skin Diseases in July,

1873. The patient was a man named John Adams, aged 45, who lived at Leighton Buzzard. I have not been able to obtain any information as to the sequel of his case. It seemed very doubtful whether the burn to which he attributed the disease had really been its cause.

The end of February or beginning of March he was pouring out some benzoline spirit for a lamp, and it caught fire. His left hand only was burnt. Now the whole of the nails of the left hand and the thumb and middle finger of the right are affected. The forefinger, ring, and little are scratched longitudinally. The right great toe is affected, and its nail has a crescent eaten out of it at its root, the convexity being forwards, just as if a mouse had been nibbling at it. The other parts fairly healthy. Right hand, distal phalanges, especially at base, thickened on middle finger and thumb. The nails much thickened. Left hand, the whole of the ends of the fingers are enlarged. The nail-structure on this hand is wholly decayed, crumbly. Looked at from the front and below, the bed of the nail is thickened. They began to crumble in a few weeks after the burn. No pain. No signs of syphilis. He had gonorrhœa when a young man. Has a healthy family of six children. The colour is of a dirty yellow, or yellowish and black patches. The enlargement of the ends of the fingers is most striking. It appears located round the distal joint. I think it is limited to the base of terminal phalanges.

November 2, 1875.—Replies to inquiry: "Fingers are much the same." Health good. Fingers do not prevent him working. Has had no treatment since coming to H. S. D.

DISEASES OF THE NAILS BEGINNING AT THE LUNULA.

I have next to illustrate a form of nail-disease in which the inflammation begins, not at the free edge and sides as in psoriasis, but at the lunula. It produces conditions which are in many respects the exact converse of what we observe in psoriasis. Thus the sides and the distal part of the nail are the last to suffer. In some instances the sides of the nails remain quite smooth and polished, whilst the central belt the width of the lunula is thrown into ridges. The conditions assumed by the nails will vary much in relation chiefly, perhaps, to the original endowments of the nails as regards thickness and soundness of structure. If the nails were originally strong and thick, they will probably under the influence of this form of disease develop hard, prominent

PLATE CLXXVII.

DISEASE OF NAILS BEGINNING AT LUNULA.

THE particulars of the case to which this Plate belongs are given at page 281. The disease of the nails had been present eighteen months, and quite recently an eruption of papules like those of lichen planus had appeared on the back. The patient was a married man of forty-three, who had never had syphilis. It appeared probable that his nails would be quite destroyed.

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ridges running vertically down their centres; whereas if they were thin, the ridges will be much less prominent and there may not improbably be definite softening of the central part of the nail. Sometimes a prominent central ridge will split as it approaches the free edge, producing a V-like cleft. This condition is well shown in the woodcut given at page 151. Immediately over the lunula itself the surface of the nail is always more or less broken and thinned away, and a not infrequent result is for the nail-fold to become adherent to the nail-bed, and to be dragged forwards as a sort of ptyrigium, having its base at the lunula. This form of nail-disease is usually very intractable, and in most cases proceeds, I think, slowly but surely to the entire destruction of the nails. It is, however, by no means common, and in making this general statement I do not speak from the collection of any large body of evidence.

The case which is illustrated in the woodcut to which reference has been made is that of a young woman, a Jewess, who has been for some years occasionally under my observation for lupus affecting the face. At one time she was anæmic and weak, but her health has much improved, and the lupus has been entirely cured, leaving, however, large scars on the face. It was of a somewhat peculiar form, and more closely resembled tubercular ulceration of the skin than lupus vulgaris does. I have never found any reason to suspect specific disease either inherited or acquired. Miss D—— is now nearly forty years of age. Her nail-disease had been in progress, at the time the sketch was taken, about two years. It will be seen that the lunulæ, as is usual in her race, are unusually well marked and large. The nail surface over them is superficially eroded. Extending forwards on all the nails is a hard, prominent ridge, which splits at its extremity. The conditions are most marked on the thumb, but involve very definitely the index and middle fingers. On the ring and little finger nothing is seen excepting a low central elevation. The disease of the nails has never been a subject of treatment, and Miss D—— would not have consulted me about it if I had not taken notice of it.

Amongst other illustrations of this form of nail-disease I may place the following:—

Disease of the Nails beginning by Softening of the Lunular Region—Repeated relapses.

A lady, named W——, aged 38, was sent to me by Dr. Campbell, of Liverpool, in July, 1889. She was the subject of a skin-disease of a somewhat indefinite character, and allied, perhaps, to lichen planus. Unfortunately I cannot find my notes describing her condition at her first visit. A subsequent note records simply that she was doing well under arsenic in full doses, and on November 20, 1890, I wrote: “Her eruption, which was fading in July, has now quite gone. She feels well, and her nails are sound with the exception of the thumbs.” She has always noticed that her first symptoms in the nails was redness of the lunula, which was quickly followed by softening and by longitudinal splitting of the nail. The nails would then become fibrous, and show lengthwise streaks or cracks, which by the accumulation of dirt in them would become dark. In the two thumbs which were still affected the lunula was at this date soft and reddened. Vesicles could be distinctly seen in its white surface, and the nail-substance was so soft that a little pressure would easily indent it. Mrs. W—— said that this was the way in which the disease always began. She had very large lunulæ, and her nails, when well, were beautifully smooth and polished. Those which had recovered under the influence of the arsenical treatment had now regained their smoothness, hardness, and gloss.

It will be seen that in this case, although the lunula was distinctly the part first affected, the conditions were not exactly those which I have described in previous cases. There was no surface erosion of the nail, nor did the conditions persist in spite of the treatment, as is more usually observed.

A Typical Example of the form of Nail-disease which begins at the Lunula, and produces Ridges running up the Middle of the Nail.

The following case is the one which is illustrated by Plate

138, and is one of the most definite which I have to adduce as illustrating that peculiar form of nail-disease in which longitudinal ridges run up the middle of the nail. The disease apparently begins at the lunula, and the sides of the nail are often little if at all affected. If the patient has naturally strong nails the ridges become well elevated and hard. This was the case in the present instance.

Mr. R—— had been my patient for syphilis in December, 1888, when he had a course of specific treatment. He did not, however, suffer in his nails until August, 1889, when he crushed his left thumb-nail so as to produce a blood-clot in or under it, which remained for a long time.

In January of the following year the nail showed ridges in its centre, and in March of the same year he came to me with both his thumb-nails affected in a similar manner, and those of the index fingers threatened. The beginning of the disease appeared to be from the lunula, from which part lines extended forwards on the surface of the nail. The nail-substance became opaque and fibrous. After this I did not see him again for three years. In November, 1893, he was brought to me again by a medical friend under whose treatment he had been. My notes state that his nails were as formerly. They were symmetrically affected, the thumbs most severely so, and the little and ring fingers little or not at all. He had taken much arsenic, as well as mercury. It was at this date that the sketch was made. In September, 1894, I described in my notes a long fluted band, about the width of the lunula, extending forwards to the free edge of the nail. It consisted of a central ridge and two lateral ones. The nails were now hard, and the ridges were quite sharp and sometimes overlapped each other. All trace of lunula was lost in all the nails which were affected, and the central part of the nail appeared to be contracted, as if nipped up, whilst the sides remained bright, smooth, and quite unaffected. (This condition has not been successfully reproduced in the plate.) There was no loosening of the nail from its bed, and the condition entailed on the patient no inconvenience other than its unsightliness. Mr. R—— had taken full doses of arsenic for a long time without benefit.

He had also taken it in combination with two-drachm doses of solution of mercury. The arsenic had disagreed with his stomach and done no special good to his nails. He had recently had slightly scaly eruption resembling lichen planus down the middle of the back and on his chest, but not in the psoriasis positions. This eruption had made its appearance whilst he was taking arsenic and mercury (November, 1894).

The following notes record the progress and state at different dates, but I may anticipate by stating that at the present time the disease is still uncured, and that the disorganisation is proceeding :

I saw Mr. R—— again on March 13, 1895. The condition of his nails was much as before ; some of them seemed a little less broken, but others were more so. Long strips of thin nail-structure would peel up from the middle of the nail through its whole length. The eruption on his back had not increased. It still occupied exactly the middle of the back over the spinous processes, and for two or three inches on each side of it. It consisted of flat-topped, brightly polished papules, not in the least scaly, and none of them larger than a threepenny-bit. They were not irritable, and, unless they had been seen, he said that he should not know of their presence. He had no skin-disease elsewhere, and was in perfect health. For the last six months he had been taking arsenic. The papules were like those of lichen planus. He had no patches on the tongue, and only very slight white markings in the pouches of the cheeks.

August 4, 1898.—No improvement from any treatment has resulted. Only one nail is now left free, that of the right index finger.

In most the central ridge, or rather two ridges, each one beginning at the margin of the lunula, is still well characterised, and the sides of the nail remain free. In some, however, the whole nail is involved, and has become shrivelled in all directions. He tells me that they scarcely require cutting, as they grow so slowly.

Clearly the process tends to arrest of growth, such arrest beginning at the lunula. Another feature is also marked : the skin over the lunula becomes adherent to the nail and is dragged forwards by it as a fan-like band (" pterygium of the nail-bed ").

Mr. R——'s nails are not in the least painful ; the disfigurement is the only trouble.

Schedule of Mr. R——'s Case.

The following schedule will exhibit in clear light the chronology of the case. It remains doubtful whether

syphilis should rank as in any degree the cause of the disease. The patient has remained in all respects in good health, his children are healthy, and treatment by mercury, in free doses and long continued, did his nails no good whatever. The disease has been steadily aggressive, just as in other cases in which there is no history of syphilis.

YEAR.	AGE.	DETAILS.
1888	25	December. Complete syphilis ; prolonged mercurial treatment.
1889	26	August. Injured one nail, causing ecchymosis.
1890	27	March. Came to me with both thumbs affected. Mercury given.
1891	28	Married with my permission (several healthy children).
1892	29	Not under my observation ; taking arsenic and mercury.
1893	30	Brought to me again by Mr. S. for his nails.
1894	31	Nails deeply fluted and look as if pinched up ; toes not affected. (Sketch taken.)
1895	32	Eruption on back, &c. (Lichen planus?) It soon disappeared.
1896	33	Arsenic again given.
1897	34	No improvement in state of nails.
1898	35	Treatment abandoned.
1899	36	Disease of nails still advancing. Health excellent.

A Case precisely similar to the preceding as regards the Disease of the Nails, but without history of Syphilis.

A man aged about sixty, who attended at my Demonstration in January, 1899, afforded us an excellent example of the form of nail-disease which begins at the lunula. The nails of all his fingers had been destroyed by it. On some of them thin plates of normal nail still remained on the sides, but in all the middle portion of the nail was lost. The pterygium condition on some of them was very marked, a band of smooth fleshy skin being prolonged from the nail-root almost to the end of the digit. The ends of the fingers were in all cases quite unprotected by nail, but they were smooth and sound, and not in the least irritable.

Our patient told us that he had been the subject of nail-disease for fifteen years, and that no treatment had ever been of the slightest benefit. The disease had in all cases begun by a ridge down the middle of the nail, and had never been attended by much inconvenience. It had been steadily aggressive, spreading from finger to finger, destroying the nails more and more. The man was married, and had a healthy family. He assured us that he had never had any form of venereal disease. There was no history of any injury to any nail, nor had any form of skin-disease shown itself.

A Case similar to the two preceding—History of Syphilis.

It was with much interest that a few days later I again inspected the nails of Mr. B——, who had exactly the same condition as in the above-mentioned case. I had seen Mr. B—— repeatedly during the last few years, and he had suffered from syphilis six years ago. There seemed good reason to believe that the affection of the nails had been in the first instance directly due to the syphilis, for it had commenced during the secondary stage. Only one nail, that of the little finger of the left hand, had escaped, and it was still quite sound. No treatment had availed anything, and Mr. B—— had ceased to care about his nails, as they gave him but little trouble. He consented to allow them to be sketched.

CASES OF DISEASE OF NAILS IN CONNECTION WITH SYPHILIS.

Severe Onychitis in the Secondary Stage of Syphilis.

A man of 39, in the eighth month of his syphilis had all his nails most severely affected. They were inflamed, painful, and exuded fetid discharge. They all fell off, and two months later, when I saw him, little remained excepting an irregular, lumpy nail, which covered only the lunula and the part close to it. At the time that his nails fell he also lost his hair. The syphilis had been very severe, and the patient, being a spirit drinker, had not carried out his treatment well.

Eczema of Nails after Syphilis—Father and Son both affected—Gout in Family—Disease beginning at Root.

In the case of a Mr. S——, aged 29, who had suffered from eczema from boyhood and who had also had syphilis (two years ago), the nails were severely affected. The disease began at the roots of the nails, and, when I saw him, the anterior halves of the nails were smooth and polished, but the proximal halves rough and deeply eroded. Probably this condition represented only a stage of the disease. His nails had suffered before he had syphilis. The eczema affected his fingers and toes badly. There was gout in the family, and he himself had suffered from it. His father also had had eczema of the nails.

Symmetrical and General Disease of the Nails in Syphilis producing Atrophy after lasting a Year.

As an example of disease of the nails in syphilis of a somewhat exceptional form, I may mention the case of Mr. S——, who was brought to me by Mr. Prickett. He was in good health, and it was about twenty months since he had contracted syphilis. His nails began to suffer six months after the primary disease, and had never got well. He had been taking mercury the whole time, but apparently in doses which were not quite efficient. He had never had either rash or sore throat, and the inflammation of his nails had been his only secondary symptom. Recently, however, the site of one of his chancres had shown a tendency to recurrent induration, and he had also had slight periosteal swelling over one rib. The nails of all his fingers and toes were affected. He said that they had been at one time a good deal inflamed and had discharged, but they were now quite dry, broken, and shrivelled up to mere stumps. Their growth seemed to have been arrested, and in most cases the anterior two-thirds of the nail was wanting.

Case of Syphilitic Onychitis.

Mr. J——, aged 50, came to me September 25, 1889, for an affection of his nails. He had had syphilis six months previously, when he had

an eruption and ulcerated tongue, and had since had two attacks of iritis. The left eye was much damaged. The onychitis of his nails was exactly like that of psoriasis of the matrix.

On October 10th he was much better in all respects, his tongue being quite well.

November 12th. Almost all his symptoms were gone, but he had muscæ before the damaged eye. His nails were better.

March 12, 1890. The right eye had improved. He now had patches of psoriasis palmaris in both palms, almost eczematous. His tongue was rather sore. He had had some conjunctival ecchymosis. His nails were now quite well.

May 29th. His nails remained quite well, but he still had some trouble with the patches in his palms.

November 18th. He has now taken the bichloride of mercury for ten months, with some iodide. He is quite well excepting the palms of his hands, and they are nearly so.

Syphilitic Disease of the Nails, beginning at the lunula and producing a soft condition, with obliteration of the nail-fold.

The case of Mr. B——, a young man of 23, offered us a good illustration of this form of disease of the nails as met with in definite connection with syphilis. His chancre did not, according to his statement, develop until after seven weeks' incubation. It was at first much inflamed, and for a time phagedænic. I did not see him until a year after the primary disease, and he had then a deep scar in the corona. He had taken mercury, but had begun it late. When he came to me (June 1, 1895) he had symmetrical bluish-white glazed patches on the tongue, exactly like those of lichen planus, and he had also rather extensive white streaks and patches in the pouches of his cheeks. The point of most interest in his case, however, was the condition of his finger-nails. All of these had inflamed, the inflammation beginning at the lunula, and causing the nail above to become soft, and the lunula itself to become flesh-coloured instead of white. The next stage was a transverse ridge, which had behind it nail so soft as to be easily dimpled by the finger, and in front the old nail was still quite hard. As the nail grew the hard portion was pushed forward, and became, of course, narrower and narrower, until at length almost nothing was left, and the rim of hard nail was shed. When

this took place the nail-bed was left covered by a thin, soft structure, which did not present any free edge, and with which the surrounding skin was everywhere united. All his nails, excepting one little finger, were in this condition. In none of them could any trace of the lunula be observed. The nails, although so soft and thin, were not tender, and their surfaces were smooth. In addition to the disease of his nails and the patches in the cheeks, Mr. B—— showed a very peculiar condition of the lips. Along the whole length of the prolabium on its middle, and exactly where the lips touched each other when the mouth was shut, there was a broadish band of dark colour which looked just as if a stick of lunar caustic had been drawn along it. The patient was a rather delicate man, not improbably in an early stage of phthisis. This form of disease of the nails begins evidently in inflammation of the nail-bed at its root. The white lunula becomes florid, and there is an arrest of the nail-making process. Thus the nail becomes little more than a skin, and is united at all its borders to the adjacent integument. Its softness is a most peculiar feature.

Mr. B——'s first visit to me was on June 1st. He came again on March 25, 1896, when I made the following note :

His nails were exactly like Mr. H——'s, with the difference that they were very thin and soft. They present exactly the same longitudinal ridges on the surface. Most of them have no free edges at all. He thinks that his hair is very thin.

I have not seen him since June, and he has taken regularly three times a day two drachms of the solution of mercury, with four grains of iodide of potassium.

The streak formerly described on his lower lip is as it was, but more conspicuous, and also faintly on upper lip. He has had his gums tender.

He never had any caustic applied ; there is some tendency to peeling of the prolabium, but only slight.

The nails at their roots have become quite merged with the skin, and adherent to it.

A persistent affection of the Finger Nails for seven years after Syphilis—Nails stumpy, with transverse furrows, but hard—History of similar affection in father of patient.

Mr. H—— G—— presented a very peculiar condition of nails (November 11, 1891). He assured me that it was confined to his finger-nails, but I did not personally examine his feet. The nails were all of them short and broken at their edges, and to a very slight extent undermined also. They presented, however, very deep transverse furrows, and these did not cross all the nails at the same level, but were quite irregularly placed. The nail-substance, both in front and behind the furrows, was quite sound, hard, bright, and polished. He had suffered with this condition of nails in spite of treatment, but with variations of severity, for about six years. They had given him no trouble, excepting from their unsightliness, and were not liable to catch or break. That the transverse furrows did not represent any particular changes in his health was proved by the fact that they were not all on the same level, and he had indeed not suffered from any special illness. He was in excellent health, of good circulation, and said that he had never known what a chilblain was. He told me that he believed that his father had in the middle part of his life suffered from a similar condition of nails, but had at length got quite well. There was no attendant skin-disease, excepting a few indefinite patches on the scalp.

I had treated Mr. G—— for syphilis seven years before he consulted me on account of his nails as above described. He considered that his nails had never been quite well since the secondary stage.

I felt, however, much doubt as to whether the condition had anything to do with the disease. His nails did not improve under specifics, and the history of a similar affection in his father suggested that there might be a family tendency. On the other hand, it might be that hereditary tendency had given proclivity to what syphilis had evoked, and that we had a mixed result.

The following notes refer to a case in which a man who was under treatment for secondary syphilis had inflammation of his nails. No external chancre had been recognised, but it was probable that there had been one in the urethra about six months prior to my seeing him. No specific treatment had been adopted until an eruption, with sore throat, was fully out.

Syphilitic Psoriasis of the Nails (loosening and shedding).

An excellent example of what I would like to understand as psoriasis of the nails, that is, loosening of the nail from its bed and accumulation of epidermis between them, occurred in the case of Mr. —. This gentleman was in the fifth month of secondary syphilis, and had a papular scaly eruption. All his finger-nails began to look dusky, of deeper red near to their borders and free edges; these changes being seen through the yet transparent nail. Rapidly the process spread backwards and the nail became loose. Two of them were just ready to fall off. The finger-ends were meanwhile a little tender, but there were no products of inflammation excepting dry scales under the nails. The nails themselves did not thicken or break up in any way.

The conditions in this case were exactly the same as those in Mrs. "Sutton," excepting that they were less acute. In the one they were syphilitic, and in the other not so.

Psoriasis of the Nail-bed in the secondary stage of Syphilis
—*Tendency to suppuration.*

I saw Mr. F—— for a second time on November 30th. He had then taken mercury for more than a month, and was slightly salivated. All eruptions had disappeared, but he had ulcers in both tonsils, and his nails were worse.

The nail of one great toe had come off, and several of those of the fingers were likely soon to fall. They were undermined in almost their entire length. In all cases the undermining had begun at the free border or sides, and progressed backwards. The nails, although quite smooth on

their surfaces, had the appearance of being opaque and of a dirty yellow, owing to the accumulation beneath. This accumulation was partly of pus, and had formed such a hard crust that it was not possible to thrust a probe under the nail. In one instance a distinct discharge of pus had been noticed, but all others were quite dry. A dusky-brown line of congestion marked the limit of the process under each nail. He complained bitterly of the aching in the finger-ends, and said that they were burning and had kept him awake all night.

At this date I added to his one-grain grey powder pill a dose containing four grains of iodide of potassium.

A peculiarity in this case is the tendency to suppurative inflammation. In this feature it approaches Dr. Hearndon's patient, but is not nearly so severe.

(To be concluded.)

PLATE CLXXVI.

FAVUS OF HANDS AND NAILS.



THIS sketch shows the condition of the hand and finger-nails in a boy who was the subject of Favus attended by severe dermatitis. The conditions due to the fungus itself were obscured by the accumulation of the products of inflammation. His head and face were in a similar condition. The fungus was repeatedly demonstrated, and contagion occurred. The case is published in detail at page 829, vol. vii.

ON THE SYMPTOM-SIGNIFICANCE OF CHOROIDITIS DISSEMINATA.

THE conditions which result from disseminate choroiditis are very permanent and very definite, and a knowledge of their significance as symptoms often becomes of great importance. Whilst we recognise that in a majority of cases, when well characterised, they imply syphilis either inherited or acquired, we are compelled to acknowledge that in others which are not easily distinguished there is no evidence whatever in support of such a diagnosis. In the absence of such collateral evidence, what value may we attach to the condition of the choroid in itself? May we assume that alone it constitutes probability? If not, what other constitutional conditions are there to which we may attribute these peculiar and well-specialised changes? Can we discover any features by which the syphilitic forms may be distinguished from those which are otherwise? It is, perhaps, more especially in reference to inherited syphilis that these questions press for solution. If we might, upon the presence of patches of choroidal denudation scattered over the fundus, confidently assume that their subject had suffered from syphilis, either in the inherited or acquired form, the symptom would become of the utmost value for diagnosis. Even if we cannot go so far as that—and I do not believe that we can—the condition yet remains one to which much suspicion attaches. In the Clinical Report on Choroiditis which I now commence, I purpose to examine in some detail a series of remarkable cases, in the hope of being able to throw some light upon their probable causation. It will be convenient to record the cases before undertaking any general comments.

CASE I.—*Very extensive Choroiditis affecting both eyes at about the age of puberty in a healthy boy—Probable interval of two years between the two eyes—Permanent and great defect of the eye first affected, with atrophy of optic disc and retina—Recovery of almost perfect vision under anti-syphilitic treatment during early stage in the second eye—No cause found—Note as to patient's state thirteen years later.*

The case of Mr. J. J. P—— was one of peculiar interest. He was under my care at Moorfields when he was 16 years of age. He was 29 when the concluding notes were taken. I had not seen him for ten years until this second occasion, when he was obliging enough, at my request, to travel up from Colchester in order to give me an opportunity of examining his eyes. He was then under an impression, which was, I think, very possibly a mistake, that he had reason to be very grateful for the results of my treatment of his case. The condition of his eyes was certainly very remarkable. I do not think that I ever saw such accumulations of pigment blotches in all parts of the choroid as his eyes displayed. Certainly never with such retention of good vision as he had. On almost every part of the fundus, and especially in the central regions, near to the yellow spot and optic disc, there were patches of pigment of all sizes. Most of them were coal-black in colour, and some of the smallest presented the crater-like condition, *i.e.*, they had a white spot in their centre. The disorganisation of the choroid extended to the peripheral regions, but was not so extensive there as near the centre. Since the sketch had been taken (in May, 1875) the pigment patches had become much more dense and blacker; but whilst this change had been going on his sight had been improving, and he could now see almost perfectly with both eyes. There never was any proof of congenital syphilis, although there was some history of his having had an eruption in infancy. His features and teeth were good.

The following is a copy of my earlier notes of his case:—

J. J. P——, a remarkably healthy and well-grown youth, came to the Moorfields Hospital in January, 1872. He was then sixteen years old. He was robust, his complexion florid, and his hair black. He showed no signs whatever of syphilis, either inherited or acquired; and, with the exception of certain facts of very questionable value to be given presently, there was no reason for suspecting either form of this disease.

He stated that about two years previously (*i.e.*, when he was 14) he accidentally found that he could scarcely see with his *right* eye; it had never given him any pain or trouble either before or since this discovery.

He came to the hospital on account of recent inflammation of the other (*left*) eye. The attack began with redness and some pain in the middle of December, 1871; there was never any discharge. He applied at Moorfields on January 8, 1872, three weeks after the attack began and the diagnosis of "Conjunctivitis (? Cyclitis)" was made. For the next fortnight he used atropine and zinc drops and took a bitter mixture.

On January 22nd his case was more carefully gone into, and the following notes, in substance, were taken:—

Vision: R. barely 19 J.; Pupil acts only in sympathy with L. L. 4 J.

Ophthalmoscopic examination: Right eye: Very extensive old choroido-retinitis; the choroidal disease consisting of abundant large patches very highly pigmented. Some of the patches were small and round, but for the most part these seemed to have become confluent in the form of irregular areas. Some of them were of a slaty colour, and a few almost glistening white as if based by tendinous or fibrous tissue; but the majority were almost covered by coal-black pigment. The region of the yellow spot scarcely showed any healthy choroid. The retina was somewhat hazy; the disc is stated to have been doubtfully pale and the retinal arteries and veins of good size.

The *left* eye showed general haze of retina, especially about the yellow spot, and there were some ill-defined deposits in the retina, or choroid, over which the retinal vessels ran unobscured. There was abundant choroidal disease at the equator in small round patches, some of which appeared to be recent deposits, the majority, however, consisting of moderately pigmented atrophic patches. He was ordered to take 5-grain doses of iodide of potassium with $\frac{1}{2}$ grain of bichloride of mercury three times a day. It is noted that he was subject to occasional "sharp aching" in the eyes, especially in the left; this would sometimes last a day or two.

On February 22nd, a month after the adoption of specific treatment, the notes state that he read "1 J. easily" with the left.

April 22nd. The same; "1 J. easily" with left. The iodide had now been taken regularly for three months, but latterly the mercury was discontinued.

I then lost sight of him for $2\frac{1}{2}$ years; in November, 1874, he wrote to say that he still had occasional slight attacks of pain in the eyes.

In April, 1875, just three years after his last visit, I saw him again. With the left he could still read 1 J. easily at twelve inches, and did not complain of the slightest inconvenience as to sight. And yet ophthalmoscopic examination disclosed an extreme condition of choroidal disease (will be illustrated in a future Plate). There were most abundant round patches, some of them more or less confluent, consisting of a whitish or grayish-white ground almost covered by coal-black pigment; the disease was especially abundant about the yellow spot, where there was scarcely any healthy choroid left. The disc and retinal vessels were perfectly healthy.

At the above date it was noted that, although the state of the choroids was very much alike in the two eyes, the condition of the disc and retinal vessels was very different. In the *right* (the defective) eye the "disc is very pale and the retinal arteries very much diminished."

With reference to cause I was quite unable to come to any confident conclusion. The patient was the eldest of two children, the younger one having died almost at birth. His parents were not related by blood. He had been told that in early childhood, at two years of age or less, he had an eruption, "was covered with spots," but this is the only fact which makes syphilis, either acquired or inherited, at all probable. In other respects his health had always been excellent. He was subject to frequent seminal emissions, but denied with every appearance of truth ever having been exposed to risk of venereal disease, and the fact that the defect of his right eye was first noticed at the age of fourteen puts acquired syphilis almost out of the question. He had not been subject to epistaxis. He was not at all deaf, and there was no history of nodes or of keratitis.

His father, aged 70, formerly a huntsman in a nobleman's establishment, was reported to have had at one time a number of "places" (probably ulcers) on his legs; this cannot, however, be taken as furnishing any certain evidence of syphilis.

The important points in this case are :—

1. The retention of almost perfect sight in an eye with very gross and most extensive disease of the choroid involving almost the entire fundus and very near the yellow spot region; the retina and nerve remaining healthy.

2. The great defect of the other eye, in which, together with a very nearly identical degree and extent of choroidal mischief, there was atrophy of disc and retina.

3. The age at which the disease occurred, and the long interval before the affection of the second eye.

4. The absence of any apparent local or diathetic cause.

There remains the possibility that he may have been accidentally infected with syphilis in childhood. This appears to me to be on the whole the most plausible hypothesis. It would fit with the absence of the usual signs of inherited disease, and it may be noted that the form of choroiditis was like that of acquired disease.

I have next to relate two cases of hæmorrhagic choroiditis both of which occurred in young men who were without syphilitic history. In both cases, seminal losses were a possible cause. The cases were probably analogous to those of hæmorrhage into the vitreous occurring in young men (with gout and constipation).* In one case both eyes were affected, in the other only one.

CASE II.—*Hæmorrhage from Choroid and perhaps from Retina into Vitreous, ending in extensive disorganisation of Choroid in each Eye—Repeated relapses—The disease attributed to frequent seminal emissions.*

Henry G—— was first under the care of my then colleague, Mr. Bowman (afterwards Sir William), at the end of 1872, and again in May, 1873. He was then twenty-two years of age. The condition of his eyes appears to have been very much the same then as afterwards when under my own care. Mr. Bowman's notes stated that there were extensive hæmorrhages into the retina, of various dates, opacities in the vitreous, and greenish plaques in the choroid; the conditions not being precisely symmetrical.

From July to September, 1874, he was again in the hospital under my care, and a drawing of the right eye was made by Mr. Burgess. When I first saw him the *right* was the worse, and with it he could not count fingers; the vitreous was full

* See ARCHIVES, Vol. I.

of films, and some parts of the choroid could only just be seen. The *left* was also very defective, but he could read 10 J. held near; the vitreous was clear, and the choroid was found to be covered with patches of absorption with large deposits of pigment. In a month the right vitreous had cleared so much as to allow all the details of the fundus to be seen quite easily. It was patched all over with pigment deposits and areas of absorption, and some of the retinal vessels were encased in whitish sheaths of lymph.* Again three or four weeks later, after an ophthalmoscopic examination, this eye became worse, but soon improved again.

I could find no evidence of syphilis anywhere about the patient; he admitted frequent exposure to risk, but denied having ever had any form of venereal disease. I was disposed to doubt his word, but, as above stated, could not support my suspicion by any appearances on his skin or in his throat. He had had no bone-pains.

The failure of sight had begun with muscæ, at the age of twenty-two, and he seemed to have had no other symptoms excepting headache, to which, however, he had been liable since boyhood. The condition of his eyes had varied very much, sometimes one being worse, sometimes the other. At one time, during his stay in hospital, the right eye was painful for a few days, but with this exception there is no note of any inconvenience excepting as regards sight. He spontaneously attributed his eye symptoms to masturbation in boyhood, and said that although he had absolutely left off the habit for six years he still suffered much from frequent emissions and was much weakened by them.

CASE III.—*Extensive Choroidal disease with Hæmorrhages in one Eye only—The disease in various stages and probably not wholly due to Hæmorrhage—Other Eye perfect—No cause assigned.*

("Amaurosis," book p. 22.) William R——, aged 26, an unmarried Irish shoemaker, was under care many years ago (about 1863). About a year previously he had discovered that

* An ophthalmoscopic drawing to illustrate this case will be given in a future number.

the sight of his *right* eye was defective, and it had remained the same ever since. I found that the field of vision was very limited, but that he could read the finest print when held near. The media were clear. The choroid was very extensively disorganised; there were many large abruptly margined patches of absorption crossed by retinal vessels, and besides them numerous small blood extravasations. The choroid at the yellow-spot itself was sound, but in almost all other parts of the fundus the patches described were seen, and probably more than two-thirds of the choroid were destroyed by them.

He denied venereal disease emphatically. There was no history of symptoms of cardiac or renal disease. He was rather deaf in his *right* ear, and had been so for some years. He was *liable to giddiness and to buzzing in the head, and had sometimes fainted. He was habitually costive.* The other eye was perfect as to vision.

CASE IV.—*Choroiditis in a healthy young woman—History of tibial Periostitis—Acquired Syphilis in infancy suggested—No evidence of inherited disease.*

The question as to whether disseminate choroiditis always presupposes a syphilitic taint became of great importance in the case of Miss L——, who was brought to me in 1877 by Dr. Lewis of Loughton. She was sixteen years of age, well grown, florid, with excellent teeth, and a physiognomy not in the slightest degree suspicious. Her sight had been first noticed to be defective two years before she came to me. She then found that she could not read well, and for a while the left eye was “bloodshot.” After a fortnight the bloodshot appearance disappeared; and then it was unexpectedly discovered that she could not count fingers. She was then brought up to London, and saw in succession several ophthalmic authorities, one of whom wished to do a double iridectomy, but was fortunately overruled by her family attendant. During the last year her right eye had failed somewhat, but she could still read fairly with it. She was liable to headaches from fatigue, with much flushing and cold feet.

She had no traces of keratitis and no iritic adhesions. In each choroid there were very numerous patches, of irregular size and of various shapes, where the epithelial layer was removed, and pigment accumulated in great black masses. In some parts the disorganisation was deeper, and a dull grey scar-like patch was produced. Nowhere was the sclerotic actually exposed, and nowhere were the conditions of retinitis pigmentosa simulated. *The patches were chiefly in the central region of the fundus and were much fewer at the periphery.* They were irregularly scattered. Near to the optic disc there was a slight haze of the retina.

The following facts may possibly bear upon the diagnosis. She was said to have suffered, when two years old, from rickets and her legs were fitted with irons, which she wore for long. At this time, as she well remembers, she had much pain in the bones, and I now find distinct evidence of thickening in front of the bones, *i.e.*, osseous nodes. In infancy she had no suspicious symptoms. Her father had lost one eye from "Amaurosis" and had the other much damaged. He used formerly to suffer "terrible pains in his head," which often kept him awake all night. He had before his marriage been under Sir Astley Cooper's care for some inflammation of his eyes.

The following is a list of the patient's brothers and sisters. Her mother, Mrs. L——, was married in 1844 and her eldest child was born in December of that year:—

1. F. Living, now married.
2. M. Died last year, 28
3. M. Died last year, 26
4. M. Died within the month.
5. M. Living and healthy.
6. M. Died of congestion of brain, of phthisis.
7. M. Living, healthy.
8. F. Living.
9. M. Living.
10. F. Our patient.
11. F. Living, healthy.
12. M. Always delicate, died 15 months.

There was no history of suspicious infantile symptoms in any of these children. None were deaf and none had had inflamed eyes. In the

patient's case there were suspicions as to vaccination, for her arm was "very bad for many weeks, and seemed as if it would never heal."

Additional Notes.—On July 13th I saw Miss L—a second time. She was looking exceedingly well. With L. she could not see 200 at 2". She thought that R. was a little worse and said that a mist came over it at times. She could see $\frac{2}{4}0$. The changes in the fundus of this eye were very conspicuous, especially near to the Y.S., where were patches over which the epithelium was removed and dense masses of coal-black pigment accumulated in their centres.

On February 26th I recorded that she could puzzle out No. 1 and see $\frac{2}{3}0$ in distance with R., but not count fingers with L. She complained of occasional headache and was liable to flush a deep scarlet over the eyebrows. She had taken a grain of the grey powder twice a day regularly since October 31st.

May 11, 1882.—Miss L—, 21. Left eye long lost. Lately the sight in the right eye has failed more decidedly. Much pain over the eyes and in top of head, attended by a scarlet state of the eyebrows; the least excitement brings them. On Friday last she had a sudden failure so that she could not see her notes of music. Next day she saw a red mist. Now the red mist is gone but black specks are falling all round like a shower. This symptom she has had for long.

She menstruates regularly but not profusely. Her head aches at these times. No constipation, but rather diarrhoea. Feet often cold. She can still see letters of $\frac{2}{3}0$. She can read letters of No. 2, but they "go and come," and if she looks intently they fade away.

My last note was taken April 28, 1885, eight years after the first. She was now twenty-four years of age. Her vision with the remaining eye was much as formerly; the left had for long been almost blind. She was thinner than formerly and more nervous, but had on the whole enjoyed good health. Her pupils were small. She had taken mercury in large courses repeatedly, and apparently with benefit to her sight.

CASE V.—*Symmetrical Choroiditis occurring simultaneously in both eyes and setting in with a prolonged and painful inflammatory attack—Excessive accumulation of pigment, much of it being in the retina—No cause found.*

P. A——, a tall spare man of 43, came to me at Moorfields in September, 1872. The conditions were precisely symmetrical both as to sight and ophthalmoscopic changes. In daylight he could see $\frac{2}{8}$ and just managed to read No. 10 J. by holding the print very close to his; eyes he said that he could not see so well by dusk; there was no limitation of the visual fields. In each eye there was most extensive old disease of the choroid with excessive accumulation of pigment. Most of the pigment was in the retina, the vessels of which were in many places covered with coal-black spider-like patches. All parts of the fundus were about equally affected. The optic discs very slightly if at all pale; the retinal vessels slightly diminished. The media were clear. There was no positive sign of past iritis, but in the right there was a small spot of uveal pigment left exposed when the pupil dilated. His hair was black, turning gray.

The patient said that he had perfect sight till nine years previously, *i.e.*, till he was thirty-four, when both eyes were inflamed. The inflammation lasted six months and was accompanied by very severe pain; all the symptoms were worse in the right eye. Sight failed during the inflammation; it improved a very little when the active symptoms subsided but never got much better; nor does it seem to have deteriorated again—at any rate it had been stationary for several years when he came under my notice.

He was an intelligent man, a preacher. It may be supposed that he had a strong motive for denying syphilis, and he did utterly deny having ever had any venereal disease; he willingly allowed an examination of his person and no trace of chancre could be found. He was married; two of his children had been born dead, but there was no history of syphilitic symptoms in any of them nor in his wife.

He was not born of a consanguineous marriage, nor was there any history of bad sight in any relatives.

He had been suffering for some time from troublesome aching in the right leg, chiefly at the back of it; mostly after walking and sometimes lasting all night. There was no swelling to be felt.

Whatever may have been the cause of the choroiditis in this case it presents some most unusual features. There can be little doubt that it began with the attack of painful inflammation during which his sight first failed. Its rapid onset, accompanied by the ordinary signs of external inflammation, and its accurate symmetry, are all features in which the case differs from all ordinary cases of choroiditis. Whether a slight degree of iritis occurred in one eye at the same time must remain undetermined.

Although the ophthalmoscopic appearances bear some resemblance to those of true retinitis pigmentosa, the case is probably not closely related to that disease.

(To be continued.)

NOTES ON SYMPTOMS AND DIAGNOSIS.

(Continued from page 250.)

No. LXXII.—*Pityriasis Rosea mistaken for Syphilis.*

The diagnosis between pityriasis rosea and syphilitic eruptions still remains one respecting which many erroneous opinions are given. Sometimes the error is on one side and sometimes on the other. One of the most instructive cases which I have recently seen I will venture to relate. A married woman, of a fair skin and in good health, was sent to me because her eruption had been pronounced to be "unquestionably syphilis." This opinion, which had been given to her with great confidence and full explanation as to what it meant, had so astonished and alarmed her that she sought the opinion of her family medical man, by whom, with an expression of doubt, she was sent to me. The eruption had then been out three weeks and covered her trunk. It was certainly exceedingly like a specific psoriasis. It consisted of scaly patches which tended to assume crescentic or annular shapes, and which spread at their edges. There was a history that one patch on the chest had taken precedence by a few days of all the others, but the rest had developed very quickly and were now arranged with fair symmetry. The eruption was almost wholly confined to the trunk and upper parts of the four limbs. All history of primary specific sores was absent, and there was no sore throat. The patient's husband was in good health. I may confess to having felt much doubt, and I recorded in my notes, "I suggest pityriasis rosea, but am not confident." Having told my patient that there was much reason to hope

that it would prove of no great importance, I contented myself by prescribing a tar lotion. Exactly three weeks later the patient returned to me quite well. Under the influence of the tar wash the patches had desquamated and disappeared, and an ill-marked white area here and there, to be found with difficulty, was all that remained. There was still no sore throat, nor had any other form of eruption followed. It seemed then that the diagnosis of pityriasis rosea was fully established.

No. LXXIII.—*On the Symptom-significance of attacks of Laryngeal Spasm.*

A lady, aged 65, gave me a very graphic history of attacks of laryngeal spasm. She said that she had had three or four in as many years, and that the last had alarmed her very much. It occurred whilst she was engaged in quiet conversation with a friend. Suddenly she became choked and had to fight for her breath. The attack lasted, perhaps, two or three minutes, and then passed off completely. During it she could walk about, but was in an agony for want of breath and was making "dreadful noises" in her throat. The previous attacks had been much of the same character. On one occasion an attack had been brought on by a surgeon attempting to apply something by means of a brush to the pharynx. The mere depression of the tongue with a spatula did not appear to risk spasm, and she allowed me to inspect the throat freely but begged me not to touch it. During the last two months another symptom had shown itself. She had suffered from a constant sense of constriction in the throat which kept her in constant alarm lest an attack of spasm should come on. It was attended by a slight sense of impending suffocation, but not by the slightest difficulty in swallowing.

There was no very obvious clue to the cause of the symptoms just described. They had persisted too long for any suspicion of malignant disease or of aneurism, and the freedom from discomfort had been in the intervals too complete. Miss P—— was a florid woman, moderately

stout, and looking well. She would not acknowledge any gout in her family, but she said that I told her that she was gouty when she consulted me on a single occasion some years ago. Although almost an abstainer, she had been threatened with pain in her great toe.

The subject of the above narrative told me that she had consulted me some years ago, and on turning to my notes on January 22, 1894, I found that she had then been the subject of neuralgia and had also complained of distressing sensations at her heart. She was liable to wake in the night with a feeling as if the heart would stop. The attacks came on only during sleep, and after lying awake for an hour or two she could usually get to sleep again. She had found that stretching her limbs was the best way to get free of the sensation. At this time she was liable to gout pains in the feet and wrists, and I advised her to abstain from wine and beer and live very carefully. She had formerly, I believe, lived rather freely. As a result of this change in regimen she had quite got rid of her trouble. Recently, however, what has been above described had taken its place.

I will not for the present venture any opinion as to the cause of the attacks of spasm in the above case. The patient is still under observation, but her dread of an attack has prevented any instrumental inspection of the throat and larynx. The sense of constriction, which has now become constant, is a symptom to be much suspected, but it is unattended by any difficulty in swallowing. From the fact that her former cardiac attacks were relieved by attention to regimen, we seem to have ground for hope that her present liability may be in connection with gout. I have been told that the irritation of a long uvula may induce laryngeal spasm of a severe character to be completely relieved by excision; a little incredulity is perhaps permissible in this matter.

No. LXXIV.—*Inability to whistle without Nipping the Nose.*

A patient told me, "I cannot whistle unless I nip my nose." He tried, and I found it was as he said; if he did not

close the nostrils, the air escaped by them. The significance of the symptom was clearly that, for some reason, his soft palate was ineffective. He could not open his mouth in the least, and thus it was impossible to examine his throat. He had a considerable gland lump in the right side of his neck. It was very hard, and its general condition suggested secondary malignant disease. There was a history of sore throat having preceded the closure of the jaws, and thus, although he was a young man of only twenty-three, I made the diagnosis of malignant ulceration involving the tonsil and fixing the soft palate.

It is clear that the ability to whistle when the nostrils are held, but not when they are open, must imply communication between the mouth and nares. Such communication may result either from perforation of the hard palate, or such destruction or fixation of the soft palate as may interfere with its efficiency.

No. LXXV.—*On the Symptoms of Origin in Paralysis of the Facial Muscles (Bell's Paralysis).*

It is of interest to record in detail the precise facts as to the mode in which certain pathological conditions develop themselves, more especially when it happens that they are described by a patient of special intelligence. The following facts were taken down almost verbatim from the patient's narration. He was the subject of a typical form of "Bell's paralysis"—all the muscles supplied by the facial nerve being still almost completely *hors de combat*. The question of diagnosis was as to whether the ailment was of specific origin or not. I was inclined to think that it was not, basing my opinion partly on the great rarity of facial paralysis from that cause, and partly on its mode of development, which was exactly like that in the ordinary so-called rheumatic cases. My patient was in good health, but he had some psoriasis of his palms, which was undoubtedly specific, and for which he was under treatment at the time that the facial paralysis occurred. His description of the advent of the latter was as follows:—

“I had, one Friday, a pain behind my left ear which I thought was neuralgia. It disappeared in the course of the evening, and during the night I slept well. On the next day, in the morning, I felt that my eyelids were stiff and my mouth also, and in the course of the afternoon this sensation increased. In the evening I found that I could not drink without holding my mouth with my hand, and this trouble was still more definite the next day. A day or two later the pain behind the ear returned, and was bad enough to keep me awake the whole night. It disappeared, however, after a day or two, and I have had no pain whatever since.”

This description was given me one month after the occurrence. So far as I could judge the paralysis still seemed to be almost complete. His lower eyelid drooped a little. He could not frown or shut his eye on the left side, nor could I detect any power of contraction in the left half of the orbicularis oris: he said, however, that he had learnt to drink on the other side of his mouth so as not to let the fluid run out. In answer to my inquiry he said that two days before the paralysis he had travelled by train on a cold day and sat facing an open window. He did not, however, at the time experience any inconvenience.

No. LXXVI.—*Urticarious Irritability of Skin.*

There is a condition of urticarious irritability of the skin which stops short of the production of actual wheals. The skin reddens when scratched, but there is no oedema caused, and consequently the raised streaks which characterise factitious urticaria are not seen. The itching is, however, precisely of the burning kind which characterises urticaria, and there is the same rapid and complete subsidence. Patients who suffer from it may scratch as much as they like without causing any permanent ill-consequences. Very usually the scratching occurs on going to bed, and on the following morning the skin, which may have been made as red as a lobster overnight, is pale and quite normal again. The same causes which produce well-marked urticaria, produce

this—fish, for instance, and more especially crustaceans. The legs are the parts most frequently affected by this form of irritability.

No. LXXVII. — *An exception to rule in the Development of "Mercurial Teeth."*

Miss M. H——, now aged 24, presents some peculiarities in a set of mercurial teeth which are worth recording. Her incisors and canines of both upper and lower jaws exhibit in an exaggerated form the usual conditions. A horizontal line crosses them all at nearly the same level, above which the teeth are deficient in enamel and very thin. They are also much discoloured. The canines are conical, but the rest are flat. All these teeth are present, excepting the outer incisor in the right side of the upper jaw. There is no gap left for this tooth; it is simply found absent on counting them, otherwise the deficiency would not be observed. The history given is that this tooth was not cut till the age of twenty, and that it then grew outwards into the lip at right angles with the alveolus. The dentist who extracted it (on account of its position) could not get it out the first time, and though he succeeded finally, declared that he had never before met with a tooth so firmly fixed. All the other teeth stand level. All four first molars have, according to rule, been destroyed by caries, and all eight bicuspid are present and free from caries. This, of course, is again according to rule; but now comes the exception. The second bicuspid is capped by smooth white enamel. The first is not perfectly capped, but shows some low spines or little tubercles projecting through on the upper surface. At the sides and over their surfaces, with the exception of these spines, these teeth are covered by sound white enamel. All four teeth are alike. Thus it will be seen that the first bicuspid have in a very slight degree shared in the damage which has accrued to the incisors, canines, and first molars, and which is usually confined to them. Can any plausible explanation be given for this peculiarity?

The explanation usually given of the escape of the

bicuspid is that at the time that the mercury is given for the treatment of the infant's convulsions these teeth are not yet formed. Their development comes later than that of the others in front and behind them. The first permanent molar is due to be cut in the sixth year, the bicuspid not till from tenth to twelfth. Thus the transitory congestion of the tooth sacs which damages the enamel organ of the earlier teeth is too soon for that of the bicuspid. But the age at which the mercury is given is not the same in all cases, and the later it is the greater will be the risk that the bicuspid may suffer; and as the first bicuspid is the first to develop, it will be the one most in danger.

If we now turn to the facts as to the history of our patient's infancy, we shall find that the period of the illness which made the mercury necessary was somewhat later than usual. According to the mother's statement, the infant enjoyed perfect health until she was well into her second year. Then occurred a long illness of a year's duration, attended by repeated convulsions and a period of insensibility. "Infantile paralysis" was spoken of, and much medicine was given during a long period. Thus it may have been not till near the end of the second year that the mercury which damaged the teeth was administered.

The above account is taken down from the statements of the child's mother, and some margin for possible error of memory must of course be allowed. The dates may not be exact. The child became, in connection with the convulsions, the subject of lamellar cataract, which caused so much defect of sight that I was induced to operate on both eyes for removal of the lenses at the age of six. She has ever since enjoyed sight and good health. She is a girl of considerable attainments, and no trace of brain damage is to be detected. Of late, however, at the age of twenty-four, she has been somewhat neurasthenic and a bad sleeper.

THE GROWTH AND DECLINE OF SYPHILIS.

MORE than twelve years ago I received from my valued friend the late Sir George Buchanan a letter which I now print. It was written, as its first expression implies, after we had been discussing in conversation what we both then believed to be an alarming increase in prevalence of syphilis.

November 28, 1887.

DEAR MR. HUTCHINSON,—As an example of what I would be at, in speaking of the growth of “ Syphilis ” (so registered) being special at the two extremes of life, and not only at the infantile extreme, let me give you these figures taken at random from the last annual report of the Registrar General, and from that of thirty years before.

ENGLAND AND WALES.—ACTUAL MORTALITY AT AGES SHOWN.

0-1			1-55	55+	All Ages.
1855	...	579	351	17	947
1885	...	1,652	478	71	2,196

0-1 deaths, you see, have more than *doubled*.

1-55 deaths are practically stationary.

55+ deaths are probably *threefold* :—regard always being had to growth of population.

Yours very truly,

GEORGE BUCHANAN.

I had often wished to follow up the line of inquiry suggested by my friend, but the pressure of other engagements had always hindered it. In preparation for the Brussels Congress, however, I determined to procure the full statistics, and Mr. J. Gregory, a gentleman well accustomed to such matters, having offered to assist me, I gladly availed myself of his help. The following tables were collated by him :—

THE NUMBER OF DEATHS RECORDED IN THE REGISTRAR-GENERAL'S RETURNS FOR
FIFTY YEARS AS DUE TO SYPHILIS.

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STATISTICAL STATEMENTS AS TO

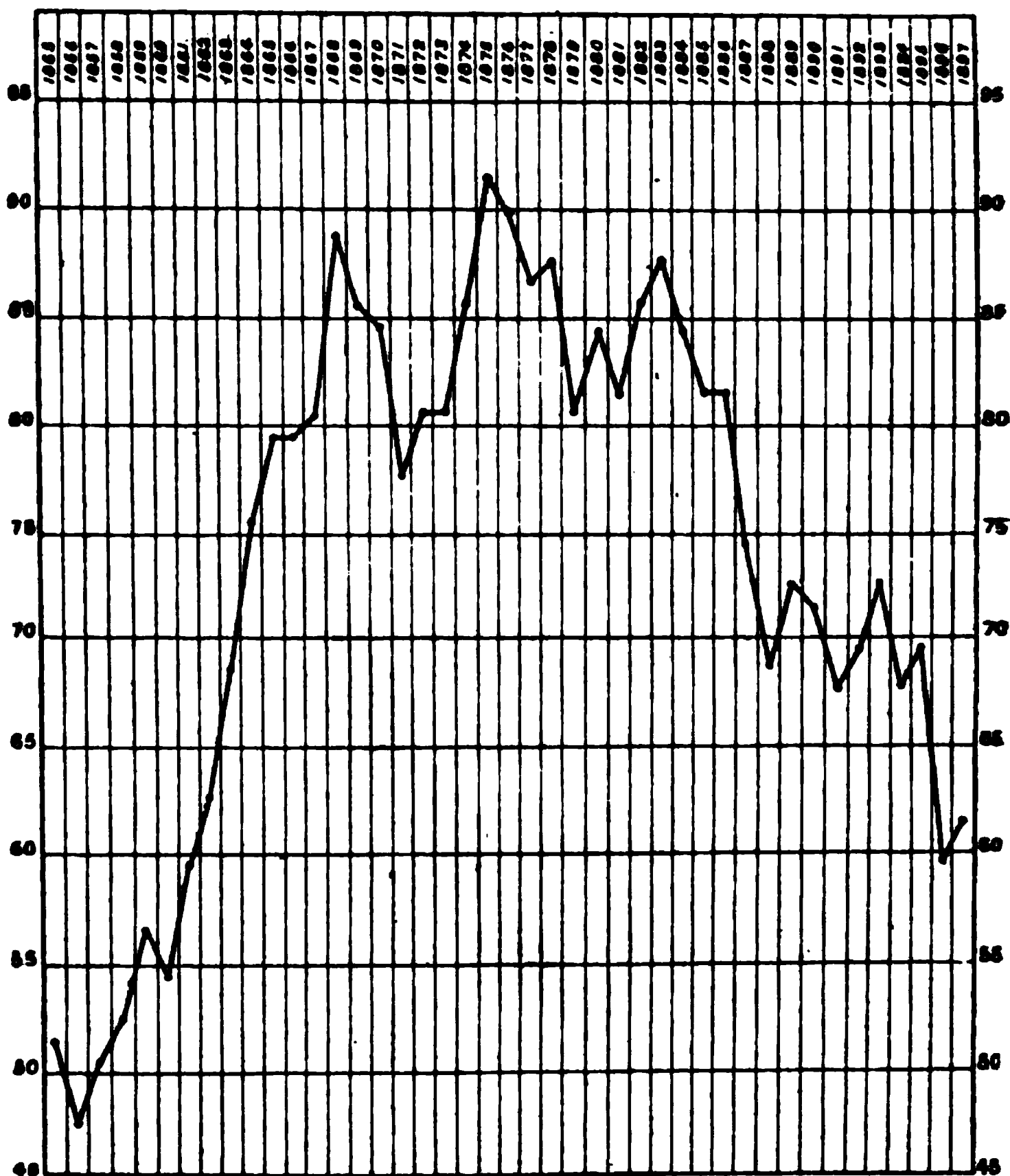
ENGLAND AND WALES (BOTH SEXES).

YEAR.	ALL AGES.	UNDER ONE YEAR.	1 TO 5.	5 TO 15.	15 TO 25.	25 TO 35.	35 TO 45.	45 TO 55.	55 AND OVER.
1848	577	..	..	..	..	..	..	..	..
1849	595	..	..	..	..	..	..	..	..
1850	554	..	..	..	..	..	..	..	..
Popn., England & Wales— Census Returns, 1851.	18,109,410	496,562	1,858,793	4,021,316	3,490,384	2,802,416	2,078,182	1,516,475	1,245,202
1851	598	..	..	..	..	..	..	..	..
1852	623	..	..	..	..	..	..	..	..
1853	622	..	..	..	..	..	..	..	..
1854	964	..	..	..	..	..	..	..	..
1855	947	579	78	13	68	101	50	29	29
1856	879	579	63	3	70	69	52	24	19
1857	957	656	58	3	69	92	45	18	16
1858	1,006	684	54	4	66	77	58	40	23
1859	1,089	778	59	16	35	90	58	29	24
1860	1,067	767	58	22	35	90	55	25	15
Popn., England & Wales Census Returns, 1861.	20,056,324	595,292	2,112,125	6,427,479	1,899,634	3,018,210	2,382,852	1,746,007	2,108,898
1861	1,177	798	84	18	52	107	62	29	29
1862	1,245	867	80	28	53	108	65	85	15
1863	1,386	983	88	24	58	116	59	85	23
1864	1,550	1,089	102	17	62	130	93	84	23
1865	1,647	1,155	124	20	65	115	85	26	37
1866	1,662	1,180	107	24	56	132	82	46	35
1867	1,698	1,241	98	15	57	118	90	52	27
1868	1,886	1,364	108	22	60	146	93	63	40
1869	1,859	1,861	131	21	46	113	96	46	45
1870	1,868	1,422	104	29	42	107	69	55	80

YEAR.	ALL AGES.	UNDER ONE YEAR.	1 TO 5.	5 TO 15.	15 TO 25.	25 TO 35.	35 TO 45.	45 TO 55.	55 AND OVER.
Popn., England & Wales— Census Returns, 1871.	22,712,206	600,850	2,204,205	7,211,177	2,004,700	2,200,973	2,271,150	1,007,730	2,418,000
1871	1,742	1,317	115	7	89	101	78	48	87
1872	1,531	1,410	108	16	25	111	85	51	90
1873	1,843	1,376	120	15	32	119	92	49	50
1874	1,997	1,484	124	13	43	129	99	65	40
1875	2,184	1,554	168	17	36	134	114	60	51
1876	2,184	1,580	186	22	37	106	125	70	55
1877	2,074	1,550	165	28	26	98	98	74	50
1878	2,182	1,647	154	17	26	120	110	62	46
1879	2,029	1,493	176	16	35	107	78	78	45
1880	2,159	1,588	201	23	27	110	93	73	44
	25,974,430	753,113	2,707,701	8,404,000	2,322,520	2,703,461	2,940,703	2,132,446	2,722,780
1881	2,097	1,540	143	19	84	116	112	62	71
1882	2,227	1,666	151	29	83	100	102	75	61
1883	2,313	1,778	183	23	90	96	96	67	44
1884	2,280	1,733	185	20	90	88	96	72	56
1885	2,196	1,652	161	22	81	106	91	62	71
1886	2,231	1,701	186	16	25	85	96	60	60
1887	2,064	1,584	122	23	26	88	83	69	70
1888	1,927	1,452	114	25	25	95	94	69	68
1889	2,053	1,500	153	17	31	116	100	76	71
1890	2,055	1,433	133	29	24	102	119	94	72
	20,002,825	754,833	2,708,957	8,500,610	2,600,413	4,377,736	3,328,006	2,400,376	3,000,000
Popn., England & Wales— Census Returns, 1891.									
1891	1,964	1,359	128	30	83	124	105	108	79
1892	2,041	1,390	146	27	98	130	105	109	96
1893	2,154	1,538	135	20	89	110	125	97	90
1894	2,011	1,453	123	17	31	94	136	84	73
1895	2,099	1,481	147	20	28	101	136	96	93
1896	1,592	1,273	105	24	41	99	116	94	80
1897	1,879	1,265	120	23	31	145	109	85	80

NOTE.—After the year 1888 the fifth and sixth columns become "5 to 20" and "20 to 25" respectively, instead of 5 to 15 and 15 to 25.

DIAGRAM OF THE ABOVE, SYPHILIS.



It will be seen that the tables include the two years referred to by Dr. Buchanan. No one behind the scenes will suppose that these numbers are trustworthy as regards the real mortality for which syphilis is responsible. No doubt in many instances the death certificate in such cases more or less intentionally conceals the true cause. This circumstance will not, however, invalidate the statistics in reference to the relative mortality in different years. It is most satisfactory therefore to observe that since the year 1875 the annual death rate from syphilis has been steadily declining. The explanation of this decline is not, it may be feared, to be

found in any real diminution of the prevalence of the disease itself. It has rather, we may believe, resulted from improved methods of treatment and from the general restoration of confidence in mercury as an antidote. The use of small doses, commenced early and long continued without interruption, and the endeavour to wholly suppress the secondary phenomena have probably been the chief agents in bringing about the result here shown.

If, however, the improved treatment of the present day has been the cause of the recent decrease in mortality, how are we to explain the reverse phenomenon which was witnessed during the two decades from 1856 to 1875? In this former period the increase in mortality was apparently most alarming. They were undoubtedly decades during which, in certain sections of the profession, there was considerable scepticism as to the benefits of mercury. The iodide of potassium was comparatively a new drug. It had done wonders for tertiary syphilis, and there was a disposition to trust it in the secondary stage which does not exist at present. Above all, there was in full vigour as a canon of practice the unfortunate dictum that no treatment should be commenced before the secondary symptoms made their appearance. Our forefathers prescribed mercury not for syphilis but for chancres. They gave it freely, and for almost all chancres, and as they did not purpose the long courses of treatment which we now do, they had no strong feeling of responsibility for exactitude in diagnosis. It may have been that by this somewhat haphazard practice they really succeeded better than we do. It may have been that the free use of mercury in the earliest stage cut short many cases of syphilis and entirely prevented the subsequent development of constitutional symptoms.

It is to be fully conceded that what I have written is, after all, based on little more than conjecture. It may be that I am wrong in assuming that there has been no material diminution in the prevalence of primary syphilis. Some social statistician may possibly be able to show that during the last quarter of a century peace and prosperity have so far favoured early marriage that it is fair to assume a con-

siderable diminution in irregular indulgence. This is possible, and it is also possible that the efforts made by many in favour of purity of life may have had a real result. Further still, it is just possible that the Registrar-General may have something to say to it, and may explain that, after all, neither the increase nor the decrease can be considered to be real, but are to be explained rather as the result of alterations in nomenclature in his office. This, perhaps, is fortunately not very probable, since both the growth and the decline were gradual. It is more likely, however, to apply to the increase prior to 1868 than to the decline since 1875, inasmuch as it is undoubted that many maladies came to be recognised as syphilitic about that period which had not been so regarded in former times. Diseases of the nervous system, for instance, make up a large group to come under this head, but I cannot think of any which are likely to have dropped out of the list of late years.

I will now examine the statistics in a little more detail, and will recur to Dr. Buchanan's question as to the mortality occurring chiefly at the two extremes of life.

Prior to the year 1855 the statistics as to the mortality from syphilis are probably of no value, or less. They represent the mortality both as regards adults and infants as very low. It seems impossible that it should have been so, and we can only attribute the great and progressive increase which ensued during the next quarter of a century, and which with only slight reduction characterises the next quarter as well, to greater candour on the part of reporters and alterations in nomenclature which enabled the Registrar to place under the head of syphilis certain maladies which were not previously so ranked.

If, then, we begin with 1855 as one of the first that is fairly trustworthy for comparison with the present time, we find a progressive increase up to the year 1875, and a progressive decline since that year, as the tables which have been given show. This diminution has been from 2,313 to 1,879, or from 87 per million to 61 per million.

This diminution is found in both the total for all ages and in that for children under one. Thus in infants it has

been from 1,773 to 1,285—a *reduction in sixteen years of nearly one-third*. There has been, however, apparently no reduction in the more *advanced* ages. If we contrast the year 1883 with 1897 for the ages of from thirty-five onwards, we find for the former a total of 207 against one of 274 for the latter, a slight increase probably in ratio with that of population. Here curiously, however, the height seems to have been reached in 1893, and since then there has been steady decline. In 1893 it had reached a total of 312, which, as we have just seen, had declined to 274 in 1897. This apparent increase in the mortality of adults up to 1893 was probably not real, but is to be explained, as already suggested, by the fact that many affections are now counted as tertiary syphilis (visceral gummata, &c.) which formerly went down under other names. Thus the improvement would appear to have reached the more advanced ages latest. If we may credit the improvement to better diagnosis and more judicious treatment in the early stages of the disease, this is exactly the result which might have been expected. Syphilis being in the main a disease of early adult age, it might be expected that the early decades would feel the effects of improvement in treatment soonest. I feel, however, the utmost reluctance to place confidence in these figures, or the encouraging lessons which they seem to convey. Such statistics are full of pitfalls for the unwary, and whoever looks carefully into the tabular statements will find many discrepancies which it is difficult to explain.

EXTRACTS FROM MY DIARY.

February 21, 1899.—Miss H—— affords an interesting example of perforation of the nasal septum independently of syphilis. She is a maiden lady of near 70, sent to me by Dr. Sheppard, of Southampton. The perforation is large enough to admit the thumb-end. Its margins are soundly healed, excepting at one spot where a thin crust forms, and which bleeds when the crust is detached. Otherwise the condition gives Miss H—— no trouble, and she enjoys fair health. It has probably been slowly progressive for fifteen years. Miss H—— lost a paternal uncle in phthisis, but she herself has never shown any chest delicacy.

Dr. J. Williams, of Barrow-in-Furness, has been good enough to report to me, under date October 28, 1898: "Moses Threlfall (the Xanthelasma case) is now quite well, and all the papules have gone." This note refers to the case recorded in Vol. I., p. 381, and illustrated by Plate 112, and again alluded to in Vol. VI., p. 270. My readers may be glad to insert in its proper place this important item of information. The case was one of a very copious xanthelasma eruption of the type known as X. diabetorum, but the patient had no sugar in his urine. He was, however, liable to attacks of very severe bilious disturbance. The first notes were taken August, 1889.

An important contribution to the statistics of the tuberculosis question has been made in a paper published in the *Lancet* by Dr. W. Carr. It had been assumed by alarmists as to

milk contagion that the cases registered as "mesenteric tabes," and as occurring almost exclusively in children, were a proof of this kind of communication. Dr. Walter Carr has shown by reference to the records at the Children's Hospital that this is, for the most part, merely a question of medical nomenclature. In reality, mesenteric tabes is very rare in children, and the diseases so recorded in the registrar's reports of deaths are, for the most part, mistakes in diagnosis, and such as could have nothing to do with the consumption of raw milk. We have in Dr. W. Carr's exposure of the fallacy referred to another admirable illustration of how statistics may be made to go with anything. No doubt in the future the term "tabes mesenterica" will be much more sparingly used on death certificates, with the result of a great apparent diminution in its prevalence. If during the next ten years the habits of the English community should materially change in reference to the consumption of uncooked milk, nothing would be more tempting than to associate the two as cause and effect; yet it is obvious that the association would be a false one.

August 15th.—The contour of an arm after ankylosis at the elbow is peculiar. I have just seen a strong, muscular man of five and twenty, in whom, since the age of five and in consequence of a compound fracture, the left elbow has been firmly ankylosed in the semi-prone position. He has been accustomed to the vigorous use of the limb, and says that there is little or nothing that he cannot do with it. The result has been that he has a large hand and a thick, fleshy forearm, whilst intervening between it and a well-rounded shoulder is an upper arm not much stouter than a broomstick. The atrophy of the long useless biceps brachialis anticus and triceps is complete, and the bone itself is thin. I inquired particularly as to the amount of disability which a stiff elbow entails. My patient assured me that he realised no inconvenience except in reaching directly downwards and in touching the lower part of his face.

August 13th.—How characteristic is the thickening of the external ear which occurs in Leprosy, and how closely in parts it approaches to what we often see in *Lupus vulgaris*. A gentleman has just called on me who is the subject of leprosy, but whose face and hands are only pigmented, and show neither tubercles nor white areas. He might be taken for a creole or a traveller fresh from the tropics, but no one would suspect leprosy who did not catch sight of his ears. They are thick and nodulated in all parts. It is the lobule which most closely simulates what is often seen in *lupus*.

August 20th.—Dr. B—— has just drawn my attention to his right testis, which is retroverted, the epididymis being in front. As his senile scrotum is lax and the skin thin, whilst the vas and epididymis generally are somewhat thickened, the condition is very easily appreciated. He tells me that he only discovered it the other day. He asks me whether it is more usual to meet with this malformation as a bilateral condition, and, if onesided, on which side it is most common. To neither of these questions does my information enable me to reply. I have seen the condition a good many times, and, as far as impressions go, should suppose it to be usually on one side only.

August 24th.—Dr. Vinrace of Birmingham sent me a lady, aged 52, with the diagnosis of *Lupus erythematosus*. Her case proved of unusual interest. She was in good health, but had lost a sister in “consumption” and a brother in “chronic bronchitis.” Her eruption consisted in an abruptly margined patch which covered the whole nose, with others, somewhat disc-shaped and ill-defined on her upper lip. I was told that the patch on the nose was often attended by extensions upon each cheek, but these latter were not present when I saw her, nor could it be said that they were represented by scars. The patch on the nose was slightly moist on its surface, and looked like “eczema,” but it was most abruptly margined, and had been present, with intermissions, for three years.

October 5th.—A woman of sixty-five, who came for another matter, told me in the course of the consultation that in early married life she had suffered a “serious illness in consequence of her husband’s misconduct.” She described a severe attack of syphilis, for which it appeared that she had been a year under treatment. I inquired if she had got quite well. “Oh, yes,” she said, “and have had a large family.” “How many children have you had?” I asked. “Fourteen, and eight are living and healthy.” “Were all born after your disease?” “Yes; that was soon after my marriage, and more than thirty years ago.” The woman appeared to be herself in excellent health, and the only trace of her bygone syphilis which I could observe was a bald tongue, with some superficial sclerosis in ill-defined, broad, whitish streaks.

Such facts as the above are worthy of being kept in mind by those who hold that syphilis is a serious danger to the community by restricting the population. It will be observed that both parents had suffered. It is also a good example of permanent recovery in the patients themselves. Neither in this respect nor as to the prolificacy of the pair do I believe that there is anything exceptional.

October 10th.—Mr. L——, a large, well-built man of forty, has a very peculiar condition of his nipples. Both are deeply sunk in a rounded hollow formed by prominent tubercles of Montgomery. The apex of each nipple is thus decidedly below the level of the tubercles, with a circular fossa between it and them. The conditions are symmetrical. The tubercles are unusually well developed. There is no enlargement of the mammary glands themselves.

RHEUMATISM AND GOUT.

No. LXIX.—*Double Morbus Coxæ Senilis (two cases demonstrated together).*

I have recorded at page 259 a case in which both hips were stiffened by the changes due to rheumatic gout, and at the same time gave references to several other cases. At a recent lecture at the Polyclinic I was able, through the courtesy of Dr. Lloyd, of St. Giles's, to again bring this patient forward for demonstration, and in the same room to produce another example of the same condition. The confrontation of these two patients was most instructive. They were almost exactly alike. They walked with the same shuffling gait, turned out their toes in the same fashion, had equal difficulty in sitting down, and resorted to similar artifices in order to get on the couch. In both there were evidences of rheumatic changes in the finger joints, but to no great extent. One had had attacks of true gout and inherited it, but the other, although dealing in paint, had never had actual gout.

In neither of these cases was there any displacement at the hip, and in neither did the degree of fixation imply any approach to ankylosis. In both a certain amount of possible movement was still present. In both, however, on both sides the femur was everted and the patella made to look obliquely outwards. In neither could either rotation inwards or abduction be effected. Neither of them could have straddled the most narrow-backed horse. In both the disease, under careful regimen appeared to be arrested. In one the large crests of bone on the upper margin of the acetabulum were easily felt in the groins; in the other not so.

When standing still, both these men stood erect, with their lower limbs straight under them, and it was only when they began to try to walk that it was observed how severely they were crippled.

In the second of these cases the patient was a short, thick-set, and rather stout man of fifty-eight, by trade a colourman. The particulars of the other have already been recorded.

No. LXX.—*Influence of Climate on Rheumatism.*

“In 1801 Coleridge settled at Keswick in a house which, if not built, was at least finished for him by a then neighbour (a Mr. Jackson), and for a time he occupied a part of it. But here his health greatly failed, and he suffered severe rheumatism from the humidity of a lake country, which was the main cause of his leaving Keswick for Malta.” (From Gillman’s “Life of Coleridge.”)

No. LXXI.—*On the dependence of Gonorrhœal Rheumatism upon inheritance of Gout.*

A case which I have just seen with Dr. Wakefield, of Nottingham Place, affords strong confirmation of the proposition which I have often maintained as to the association of gonorrhœal rheumatism with inheritance of gout tendencies. Our patient, a young man of twenty-two, has had three gonorrhœas, and after each has been threatened with rheumatism. On one occasion one knee became full of fluid. His last attack, the one for which I saw him, has been the worst, the arthritis shifting from joint to joint, and having already kept him in bed several weeks. On one occasion he believes that he cured a knee for which rest had been enjoined by persisting in lawn tennis.

Now this youth’s family history of gout in predecessors is most strong. His father and grandfather had suffered, and what is yet more, he himself, before he had had any gonorrhœa, had had several definite though mild attacks of gout

in his great toe. Dr. Wakefield, at the time of our consultation, mentioned to me another case in which he said the evidence was equally strong.

No. LXXII.—*Gonorrhœal Rheumatism with Gout in the patient himself and his relatives.*

Yet another example in illustration of the connection between gonorrhœal rheumatism and the inheritance of gout has just occurred to me. A young officer in the army was brought to me for iritis, and with the history that he was just recovering from a severe attack of arthritis after gonorrhœa. He still had a slight gleet. Although only twenty-six, he had suffered from typical gout in the great toe, and a brother of his had also had more than one attack. At the time that the gonorrhœa was contracted the patient was in good health and quite free from arthritis. He had, however, before that been twice laid up in the spring months by rheumatism. Two months after the gonorrhœa, and whilst some discharge still persisted, inflammation of one great-toe-joint occurred, and was quickly followed by synovitis of the ankle, knee, and other joints, with considerable effusion. Two months later still, in March, 1899, acute iritis in the right eye occurred. It was for this that I was consulted. The synovitis had now subsided, but the patient suffered from the characteristic gouty pain in one tendo achillis. He could now walk fairly well, but felt his knees weak as if they would give way, and was unable to stand on tip-toe on account of pain in the great-toe-joint of one foot and in the tendo achillis of the other.

No. LXXIII.—*Severe local tenderness and pain, apparently in connexion with Peripheral Neuritis of gouty nature.*

It seems highly probable that peripheral neuritis, often very local in its distribution, is a common occurrence in those who are gouty. Sometimes it is attended by numbness, sometimes by the occurrence of electric shocks on

pressure, and sometimes by very severe pain. The transitory nature of the symptom after a certain duration is one of the features which connects it with gout. Other facts also bear testimony to the same effect, such as the simultaneous occurrence of joint pains, the presence of free uric acid in the urine, and the cure by attention to diet. I knew a gouty gentleman who, although able to walk freely and without the slightest pain, could not kneel on his right knee on a soft cushion without inducing a shock of severe pain. In the course of a month or two the liability ceased, but the skin overlying a certain part of the knee was left numb. This numbness after a time passed away, but after an interval of some years he had another attack.

Another patient, under similar conditions, suffered from exquisite 'tenderness in certain parts of the tips of some of his fingers. If he chanced to touch anything with the affected parts it would make him cry out. After about a month's duration the liability passed away, and he has since been quite free from it.

The patient to whom the following brief notes refer was a very robust-looking man, and one who might have been expected not to complain about a little. He came to me, however, repeatedly making lamentable outcry as to the pain he endured in one thumb-end. He referred the pain to the pulp of the thumb. It was constantly present, but was aggravated by pressure. I examined the thumb repeatedly, and could find nothing. There was not the slightest swelling. After nearly a month of weekly visits I lost sight of my patient. The following note records his cure.

On July 16th, Mr. J—— came to me about another matter and reported his thumb quite well. The pain had finally ceased about a fortnight ago, and he could now sleep well and had not the slightest of either tenderness or spontaneous pain. He attributed the cure to the vigorous use of the aconite liniment. This (without dilution) he had rubbed in perseveringly. It had caused exfoliation of the epidermis of the whole thumb-end. Mr. J—— was at the same time taking a dose containing ten minims of tincture of aconite and fifteen of the tincture of seeds of colchicum.

It is after all possible that the cessation of the pain was spontaneous and not to be credited to the drugs, for I have known similar forms of local pain in gout to persist for a like period and then cease altogether. The great severity of the pain, and its being present constantly and independently of pressure, were the peculiar features in Mr. J——'s case. I had treated his brother for gout, and he was himself a large-made man of gouty proclivities. He had, however, been abstinent from stimulants.

It seems very difficult to explain such cases, excepting on the hypothesis that there is such a thing as gouty inflammation of the end-organs of nerves or of smaller twigs. It seems, perhaps, more probable that local groups of nerve-papillæ themselves are affected than that it is a neuritis of a trunk. It may be, however, that in some cases both structures are affected, or that the affection may ascend from papillæ to nerve-filaments. It is very probable that in leprosy the neuritis is of the papillæ in the first instance, and of the trunks as an advancing infection.

LEPROSY NOTES.

DR. GEORGE NEWMAN in his admirable Handbook of Bacteria (just published by John Murray) gives us a good summary of the facts as to leprosy. Of the parasite he says that "it has a form very similar indeed to the *Bacillus tuberculosis*," but adds that it differs from the latter in its tendency to be gathered together in clumps or colonies rather than to be isolated or scattered. Young lepra bacilli are motile, but old ones not so. He alludes, evidently with some doubt, to Neisser's opinion that the bacillus possesses a capsule and spores, and also to the claims of Italian observers to have grown the bacillus on artificial media. The suggestion (Bordoni-Uffreduzzi) that it may have a saprophytic as well as a parasitic stage of existence is treated as being plausible and possibly important. He admits that inoculation experiments have proved unsuccessful, but still thinks that "Nevertheless there is little doubt that leprosy is a bacterial disease produced by the bacillus of Hansen."

In reference to the disappearance of leprosy from the British Islands, a subject on which Dr. Newman is an authority, he having gained a prize for his Essay on it, his statements are vague. He does not mention segregation as even a possible influence, but speaks of the natural tendency of the disease, under favourable hygienic circumstances, to die out. In these conclusions I entirely agree with him, for I do not believe that segregation has ever had the slightest influence on the prevalence of the disease. It is necessary, however, to attempt a little precision as to what is meant by "improved hygienic con-

ditions," for we must remember that leprosy often occurs in very salubrious climates and to persons who have enjoyed every advantage as regards food, clothing, and general comfort. There must be some one very special influence which is included in the general expression "improved hygienic circumstances." That that influence is the omission of salted and uncooked fish from the dietary, is to my mind beyond doubt. Dr. Newman (p. 312) says that "leprosy appears in districts where no fish is eaten," but he does not tell us where those districts are.

During the six months that our Polyclinic consultations have been carried on I have been fortunate enough, through the kindness of friends, to be able to produce before my class no fewer than five examples of leprosy. One of these has attended several times, and thus good opportunities have been afforded for the study of diagnosis. All have, however, been examples of the same form, the macular, anæsthetic or mixed. In one only was there tendency for the formation of anything deserving the name of a tuber or tubercle. Since, however, there is every reason to believe that the different forms which nosologists delight to classify are only stages of one and the same malady, the importance of demonstrating the tubercular or late stage is of the less importance. What is especially desirable in clinical teaching is to give opportunities for the study of the earliest symptoms. This is, indeed, almost the only stage in which we see leprosy in England, for most patients return home in the early stage, and having got home, but few advance beyond it. To see the hideous deformities and mutilations which are the stock subjects for photographic and pictorial illustrations the observer must still go abroad to regions where the disease is endemic, where for the most part no attempt is made to keep from the patient the article of food which is the cause of his disease. In nearly all Leper Establishments fish is an article of large consumption, and according to my creed we need not wonder that the disease advances from bad to worse.

One of my patients who has twice attended at the Polyclinic is a good example of cure. He has now been for six years without any active manifestations. He is free from any obvious deformities, but his hands and feet are anæsthetic. All the other patients were males who had resided in leprosy districts, but in none had there been the least hardship in the mode of life. In no one could the slightest history be obtained of exposure to risk of contagion ; whilst in all the patient had lived with his relatives without any special precautions and without any ill results. It is a matter for interesting speculation in cases of what may be called sporadic leprosy as to whether a food hypothesis or contagion be the more probable. Those who now attach great importance to the accidental introduction of the bacillus from without, in the case of tuberculosis, accept two or three different modes of access as possible. It may be implanted by a wound of the skin, may be inhaled into the lungs, or may be taken into the stomach with food. The same offer themselves for consideration in the case of leprosy. There is scarcely a particle of evidence in support of the belief that leprosy is ever introduced through the skin. Primary sores are never observed, and although vaccination or mosquito bites have in turn been suspected, yet no one has suggested that in such cases local changes are observed. Nor is the inhalation hypothesis in the least probable in the case of leprosy. Leprosic changes are never observed first in the lungs, although they often end there, death by phthisis being common in lepers. If cases which could be correctly described as sporadic—that is occurring to single individuals in communities in which the disease has for long periods been unknown, were frequent, the food-hypothesis would receive powerful support. It would be easy to suggest that here and there an individual had acquired peculiar tastes or been forced into peculiar habits of diet. If on investigation any peculiarity of diet could be discovered as common to all attacked, we might soon feel on safe ground. Unfortunately, however, for the prospect of discovery from this class of facts the cases of sporadic origin are very rare.

DISEASES OF THE SKIN.

No. CXVI.—*An Eruption somewhat resembling Psoriasis Guttata, but without Scale Crusts, and of only temporary duration.*

Mr. T——, when he first came under my observation on March 30, 1894, was thirty-four years of age, a stout, rather pale man. He had an eruption, which he said had been out three months, and which I described as much like guttate psoriasis, and as occurring on the backs of the limbs and tips of elbows and outer sides of thighs. It was in the latter positions that it most resembled syphilis. I wrote in my notes, "It is one of those eruptions so difficult to tell from syphilis, but I do not think that it is such." He had a scar on the glans-penis, and there was an obscure history of possible contagion at the age of seventeen (that is eighteen years ago). . . He had never been treated for syphilis, and had never had any definite symptoms. He said that in spring he had often had some sort of an eruption. After a single consultation I did not see Mr. T—— again for four years. The following notes refer to the second occasion.

Mr. T——, æt. 38, September 28, 1898. He is a stout man, in excellent health, but dyspeptic and gouty. He has been from boyhood liable to a scurfy scalp, and used to chafe behind his knees, and had a "scurvy" patch on his chin. His present eruption has been out *for three weeks*, and consists of guttate spots over the limbs and body. They are grouped in the sides of the abdomen in large coalescing patches. On the limbs they are scattered

irregularly, and occur both back and front. Some of the largest are near the tips of elbows. None of these spots show any scale accumulation, nor are they materially thickened. They are almost solely the result of a local desquamation, and the margins of the torn epidermis can be distinctly recognised. In this feature they differ from psoriasis. The first patch of the present outbreak was on one arm, but the others quickly followed.

I am told that the remedies which were prescribed at our first consultation, March 30, 1894, were quickly successful, and that the skin was soon quite cleared, and, further, that from that time to the present attack there had been no relapse. He admits, however, in qualification of this that he has seldom been very long without some signs of irritation about his elbow-tips. Dr. Clapton, who comes with him, and under whose observation he has been throughout, tells me that he has never consulted him about the skin, but only for dyspepsia and gouty symptoms. Throughout there have been some persisting lichen marginatum patches in the middle of his chest, which he has had almost all his life.

The mode of evolution in this case is not like that in an outside contagion. The eruption is quite symmetrical, and is arranged much like a psoriasis. The patient himself is inclined to attribute it to his having been travelling, and drinking the wine of the country more freely than usual. He has been feeling gouty.

No. CXVII.—*Minute Comedones arranged in groups across the Loins in a Girl.*

A girl of seventeen was brought to us from Dr. Rankin, to show a very peculiar condition of the skin, extending almost symmetrically across both loins. The rest of her back was perfectly clear, and showed not a single spot of any kind. On the region referred to were a multitude of little black spots not so big as pins' heads, and all alike. None of them were in the slightest degree inflamed. Some of them presented minute sebaceous horns, and all were distinctly perceptible to the touch. I at once diagnosed a comedonous

form of acne, and by ejecting some of the little plugs this opinion was confirmed. On searching other parts of the skin we found a few small comedones on the face, not, perhaps, more than half a dozen, and on the legs were a very few. The backs of the arms above the elbows were rough with lichen spots, the *cacatrophia folliculorum*, but showed no comedones. The skin generally was perhaps a little harsh, with tendency to xerodermia.

I expressed the opinion that the girl's skin was not structurally quite perfect in its endowments, and there was thus a tendency to inaction on the part of the sebaceous glands. At the same time there appeared to be no proclivity to inflammation, and the little plugs did not cause any irritation. Their location on the loins might be due to the pressure of the girl's dress, and possibly to the local presence of some parasite.

No. CXVIII.—*Lichen Scrofulosorum as a Symptom.*

On October 2, 1893, having occasion to ask a young man of twenty-one to strip in search for a syphilitic eruption, I found numerous patches indistinguishable from lichen scrofulosorum on his back and chest. He thought that he had had them from childhood, and said that he had been considered a very delicate boy. The eruption was in part diffuse and in part in ill-defined patches, and consisted of minute lichen spots which made the skin rough. In some parts a slight blush of congestion marked the patches. He had some lichen spots on his cheeks, which were leaving minute pits as scars.

Mr. F—— came under my care for a parchment chancre on the skin of penis and sores in tonsils. I gave him a long course of mercury (to slight ptyalism) with some iodide. Under this he did well, and I saw no more of him for five years. In the meantime he had entered the army, and enjoyed much improved health. In September, 1899, he consulted me for a gumma-ulcer in posterior pharynx, being at the time quite well in all other respects. He had developed into a robust-looking man, and had got rid of both acne and lichen. The occurrence of the sore throat

had much surprised him, for he had been in excellent health.

The case illustrates the apparently beneficial effects of a long mercurial course in a scrofulous constitution, and is also of interest in reference to the value of this form of lichen as a symptom and the prognosis which is justified.

No. CXIX.—*Keloid-like Nodules in Young Children.*

I have long had in my collection of drawings two water colours representing at different stages a very remarkable local growth which occurred upon the back of a young child. The child remained under my observation for several years—or rather I should say that through the courtesy of Dr. Dowding, of Wanstead, I was enabled from time to time to observe its progress. When first it came under my notice there were three or four little buttons of induration, arranged more or less in a line, on the left lumbar region. They were unattended by any irritation, and had not been preceded by any injury to the skin. Although more or less like keloid of scar, they differed from it in being less hard, less glossy, and in having no spurs. The skin at their base was also somewhat reddened, a condition not usually seen in keloid. For several years the patches continued to very slowly increase, and we often debated as to the propriety of excising them. No radical treatment was, however, adopted, and we contented ourselves with rubbing in a little iodide of lead ointment. Finally the little nodules softened down and almost wholly disappeared, leaving, however, a considerable area of dusky pigmented skin. It must be admitted that the progress and final result in this case more nearly resembled what occurs in keloid than that of any other malady. It may have been that the extreme youth of the patient modified the appearances presented. Many authorities saw the child, and none were inclined to diagnose the case as keloid. It was feared that it might prove to be sarcoma. The part affected was one not unlikely to have been injured by a pin.

I am particularly interested in the case above narrated

from the circumstance that another, apparently its counterpart, was brought under my notice by an excellent water-colour sketch exhibited by Dr. John Thomson at the recent meeting of the B.M.A. at Edinburgh.

Dr. Thomson's patient was, again, a young child. The little lumps, almost exactly like those in my case, were developed along the side of one hand and on the index finger. There was no known history of injury, but the similarity in appearance to keloid had suggested that diagnosis. They were believed to have not been congenital.

No. CXX.—*A Case of Congenital Pemphigus.*

(WITH PLATE.)

Miss Frances B——, aged about 30, attended at my clinical demonstrations, June 25, 1895, having been brought by Mr. Hichens.

Her history was that from infancy her skin had shown a tendency to blister wherever exposed to sun and wind. Any local irritation or slight injury always produced a bulla, and the bullæ showed a tendency to spread at their borders. Her skin was dry and "crinkly" (tissue-paper-like) in all parts. Her face was much scarred, but as she had suffered from small-pox it was difficult to say to what the cicatrices were due. All her nails were destroyed as regards their distal three-fourths.

We were told that her parents, and three brothers and two sisters—the whole family—had sound skins.

The portrait taken by Mr. Burgess shows the back of the right hand and the front of one leg. It will be seen that the destruction of the nails has proceeded from before backwards. Only the stumps of broken nails remain, the nail-bed being dry and skin-like. On the leg a large excoriated patch is seen, with vesications at parts. A large isolated bulla is also shown.

No. CXXI.—*Crusted Lips.*

Another example of the peculiar symptom of crusted prolabia has just come under my observation, the patient being

PLATE CLXVII.
CONGENITAL PEMPHIGUS.

THIS Plate shows the back of the right hand and the front of the leg of Frances B——, whose case is described in the text on page 854.



PLATE CLXVII
CONTINUED FROM



FIGS 100-101, same as before, of the right hand and foot of the
tree trunk of Figure 100, whose end is indicated by a line
on page 354.

PLATE CLXV.

CONGENITAL PEMPHIGUS.

THIS Plate is placed for convenience in juxtaposition with the previous one, since it illustrates a similar case. The patient was a young man whose mother and several of whose brothers and sisters had suffered in like manner. His mother's nails had been destroyed like his own. The nail-bed was covered with skin. The case is published at page 317, vol. viii., but without the Plate, which is now given for the first time.

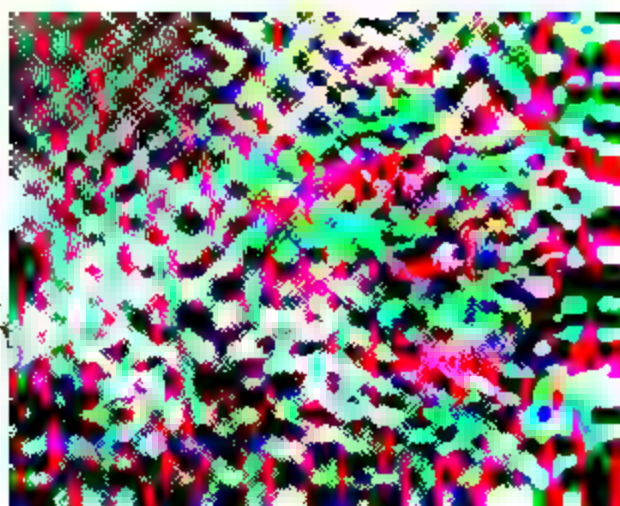


PLATE CLXX.

C. G. VON F. 1845

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The following plate is a reproduction of a photograph of a portrait of a man, which was taken in 1845. The man is shown from the chest up, and is wearing a dark coat and a white shirt. His mother's name is not mentioned in the text. The portrait was given to the author by the man's son. The portrait was given to the author by the man's son. The portrait was given to the author by the man's son.

a delicate girl, aged 23 (Miss A. M——). Her case was exactly like others, the prolabium of both the upper and lower lip being covered with crusts, which were usually shed about once in ten days.

The condition had been present for about fifteen months, and was getting worse rather than better. She had already had a good deal of both local and general treatment. When the crusts fell, parts were left raw and sore. Only that part of the lip which is exposed when the mouth is closed was affected, and the lower lip, which had been first attacked, was the one which suffered most.

DISEASES OF THE NERVOUS SYSTEM.

(Continued from page 259.)

No. CIX.—*Myelitis, with Paraplegia, without loss of Sensation, many years after Syphilis—Partial recovery under specifics long continued.*

Mr. P——, ætat 36, had been under my treatment in 1881 for syphilis. He had for many years since enjoyed good health and led a laborious life, with probably free indulgence as regards sexual matters and the use of stimulants and tobacco. On January 26, 1899, he was brought to me unable to walk, or even stand, without assistance. He had no loss of sensation anywhere. His knee-jerks were greatly exaggerated. The optic discs showed some doubtful appearances of haze at their borders in parts, but they were not swollen and were in most parts clear. His hands were tremulous and his head also to some extent, but he had a fairly vigorous grip and could speak clearly. He was emotional, and several times during our intercourse burst into tears with hysterical sobbing. It was difficult to get a clear account of his symptoms, but it appeared that he had been failing in his legs, &c., for three or four months. The inability to walk, however, had come on during the last fortnight. About three weeks ago he had ridden on his bicycle eighteen miles, and three months ago he had engaged in partridge shooting. The symptom which was chiefly insisted on as having been precursory was pain or "neuralgia" in the head, chiefly in the left occiput. This, however, had not prevented him from pursuing his duties in public. He had for long been sleeping badly, eating but little, and drinking whisky and

smoking in excess. There had been no severe backache, but of late pain had been complained of in the right haunch-bone. In the early part of his ailment he had been much troubled with urgent desire to make water, but latterly this had ceased, and he had found difficulty in expelling it. His pupils were of medium size and sluggish. He could see $\frac{2}{8}$.

Mr. P—— came to me for a second time on February 23, 1899. He had been salivated, and the mercury had in consequence been left off. It was thought that he had very much improved. His pain in the head was less, and he could now dispense with the catheter. He looked ill, however, and walked very badly. He could not walk across the room without assistance. Knee-jerk still very excessive. Pupils usually rather large, but contracting readily on exposure. I noticed that his eyelids seemed to droop, and that he threw his head back when he tried to look forwards. His wife said she had noticed this. He had, however, no paralysis of any ocular muscle. He had been reading his newspaper every day and had no mental disturbance. His nurse told me that when he took an aperient he could not retain his motions.

October 1, 1899.—Eight months have now elapsed since the above notes were taken. Under the steady exhibition of mercury in pill with iodide in mixture, such progress has been made that Mr. P—— can now, with the aid of a stick, walk fairly well. The drooping of the eyelids has passed off, and he has no trouble with bowels or bladder.

No. CX.—*Case of Acroteric Sclerodermia with liability to Raynaud's Phenomena.*

The following notes refer to a most typical example of acroteric morphœa which I have already published in much detail. It is of great importance to continue the narrative of such cases and bring them as nearly as may be to a conclusion. Mrs. M——'s case will be found in my Clinical Lectures on "Rare Skin Diseases," p. 341, and my narrative now extends over twenty-three years. It is one of those in which proneness to Raynaud's phenomena occurred in association with

acroteric sclerodermia. It began in early life, and may be considered to have now resulted in such recovery as is possible. At any rate the liability to peripheral gangrene has come to an end. Her hands and face have been permanently damaged, but her general condition is much better than it was fifteen years ago.

Description of Mrs. M——'s condition in the summer of 1899.

Mrs. M—— is now 55, and has been a widow five years. She has fairly good health, and is in all respects better. Face covered with large and very conspicuous stigmata. A few small ones on backs of hands. Both fore-fingers have lost their terminal phalanges; all the others keep their nails, but in a much dwarfed condition. The nails are very short, and the pulps of fingers are shrivelled.

There is much tendency to cancer in her family. She thinks that her paternal grandfather had true gout, and his knuckles were deformed. Her father and mother were both rheumatic. Her fingers are very stiff and wooden, and with the whole hand pale and rather waxy-looking. Radial pulse of fair power and soft. She makes great complaint of a dull aching in the left iliac fossa. I can find nothing, but it is exactly the part of which Mr. D—— (also the subject of sclerodermia) has made such persistent complaint. Formerly I diagnosed a uterine fibroid, but I cannot now find it.

On the outer side of her left foot (region of short peroneal nerve) she has a large patch of dusky, mottled skin, almost resembling scar, the remains of an ivory patch. There is a scar over the external maleolus. The rest of the foot is healthy, and so is the skin of the leg. The existence of this local patch is a valuable connecting link between zosteriform and acroteric morphœa, proving that they may occur in the same case.

There is a small patch of doubtful character over the outer maleolus of the opposite foot, but none on the foot itself in the region of nerve distribution.

The skin of the face, nose, cheeks, lips, &c., is uniformly

somewhat tight and a little waxy, but there are no ivory patches, and everywhere it can be pinched a little. The stigmata, as already stated, are very large and conspicuous.

Several years have now elapsed since she had any threatenings of gangrene on the digits or elsewhere, and the nutrition of all these parts has definitely improved. The skin of the forearms, over the wrists, &c., is slightly tight, and gets softer as we pass upwards. On the anti-helix of each ear, which is prominent, there is a slight abrasion (dry).

No. CXI.—*Peculiar forms of Muscular Failure in Old Age attended with some symptoms of Myositis.*

Some very peculiar forms of muscular failure in the lower limbs appear to be incident to advancing age. Shakespeare has stigmatised the “most weak hams” of old men, and their shuffling gait is also a well-known condition. In some instances, however, affections of the muscular system set in rather suddenly and are attended by pain and other phenomena implying active disease. I am at present seeing a case in which a man, apparently in vigorous health, is rapidly losing his walking power and has been obliged especially to note that he cannot lift his feet to a high step. He has at the same time had much vague pain in his thighs, and his quadriceps muscles are distinctly tender when suddenly touched. In connection with his case, which I shall probably record in detail at some future time, I may place the following fragment from a note-book of several years ago.

A gentleman of 66, after having been exposed to “a chill” whilst sitting for a long time in the open air, was seized with cramp in both legs and pain about the pubes. He never had any bladder symptoms. Pain in the penis and the pubic region persisted, and although he became able to walk pretty well, and even went out shooting, he lost the use of his adductors and the extensors of his thighs. He believed that

it was the fear of producing pain about the pubes which in the first instance rendered him unable to use these muscles. He was seen by me five months after the beginning, and was then in fair health and able to walk, but could not cross his legs. His father had been "paralysed" for many years before his death.

I have no further note as to this patient's progress, for I saw him only once. The affected muscles were distinctly wasted.

NOTES ON INSECTS AND OTHER PARASITES WHICH ATTACK THE SKIN.

DURING the hot weather of summer and autumn many cases of eruptions on the skin will be brought under observation which are due to local causes only. Their victims are almost always prone to suspect a constitutional one, and are often most unwilling to admit the diagnosis of bites even although insects so innocent as midges or the harvest mite may be those alone suspected. Even where there is no prejudice in the matter it is often difficult to make the correct diagnosis seem probable. It may be that only one person has been attacked where many have been exposed ; that no insect has been detected and that the severity of the eruption is out of all proportion to so slight a cause. In order to avoid being misled, it is necessary that the observer should constantly bear in mind that the insects which attack man often show the most definite preference for one individual over another. During a summer walk when flies and gnats are about, the presence of one favoured person may wholly protect from attack four or five companions. Many persons seem absolutely unattractive. Next, it is to be borne in mind that the peculiarities of the tissues of different persons, those which may be summed up in the word idiosyncrasy, are such that of two persons who have been equally bitten, one may show an eruption quite alarming in severity, and the other almost nothing.

Proposing to make some running remarks on the natural history and habits of this group of enemies of the race, I will begin with the Harvest Mite, an insect very local in its occurrence, but probably well known to many of my readers. In the autumn of 1897, a gentleman attending

my demonstrations at Park Crescent brought us an insect which I recognised to be one of these mites, and gave us a graphic account of the annoyance which he had suffered from its attacks. At my request he (Dr. MacLennan) was good enough to write out the following account of them :—

“ DEAR SIR,—The following are a few of the points I have observed regarding the insect which you have been kind enough to look at. The insect attacked principally myself, who had gone to S—— for the summer months from July till September. Each year I have been there this insect has become attached to me, and usually, as far as I can remember, on the third, fourth, or fifth day of my visit. The last two occasions the insect has become active on the fourth day.

“ One forenoon I was bitten on the knee by some insect. In about one minute more another bite took place, and I immediately inspected the area and found a small bright, brick-red spot working its way into the skin alongside a hair. This was picked out, and found microscopically to be an insect. Innumerable others produced such an effect that active treatment was necessary.

“ Liquor ammoniæ was applied locally to the bite-marks, which were very evident and were excessively itchy. Sulphur ointment was also applied generally all over the body, and the trouble disappeared rapidly. After subsequent attacks due to the same insect, inquiries were instituted.

“ It was found to attack the visitors. I could find no case where a ‘native’ had been afflicted. My brother and sister, who resided there permanently, were also attacked, the latter with excessive disfigurement, the bites producing large patches the size of a five-shilling piece, and even larger. One such produced a large patch about the size of the palm of the hand on the skin, and gave appearance of cellulitis.

“ After getting rid of the insect it does not appear to return that season, though I have had two solitary bites from insects about one month after an attack. The insect infests the ground and probably it is on the seashore, as this is the only place where all who had become affected with the parasite had been. The usual attack is above the boot or shoe, or above the stocking. The insect is not single, but two or three or more attack simultaneously. Last August so many visitors were affected by it, it was almost an epidemic. A spontaneous cure seems to take place, but only after the insect has implicated the whole skin and produced great distress.

“ The last attacks were treated by baths in weak creolin solution, one being sufficient to effect a cure. The insect readily passes from one person to another if they come much in contact. Bed linen is readily infested.

“ The appearances of the skin after a bite are remarkable. A large inflammatory œdematous swelling rises almost immediately. A small slough may come from the place where the insect entered. The hairs of the affected portion can be lifted out without causing pain. If scratching

be not indulged in, the reaction against the entrance of the insect is much less. In an infant attacked a large number of vesicles were produced. Itching was here evidently extreme. Under creolin treatment it quickly subsided. The infant was only attacked after a visit to the seashore. She had been in many fields, but never had a single mark previously."

As a suitable pendant to my friend's account, I may give the following. It is taken from a communication by M. D. P. in *Science Gossip* for October 1, 1868.

"My own present experience of its attacks is most distressing. In former years when in the country I have suffered much from its ravages, but of late I have not come in their way. A fortnight ago I came to a country lodging by the sea, and for the first four or five days confined my walks to the sands. During that time no insect attacked me. But then I bent my steps countryward and ascended a little hill behind the house, my pathway lying between potato grounds. On my return I discovered a little hillock on my flesh, and seated on it a small scarlet creature, with whose aspect I was but too well acquainted. Soon another and another appeared, and by the evening of the next day I had from fifty to a hundred of these little horrible brutes sticking in my flesh and making me rend it in such anguish of mixed smarting and itching as I cannot describe. In the course of the second or third day the suffering abated, and by the sixth I had pretty well recovered from the attack. That evening (which was that of Saturday, August 15th) I visited some friends and walked round their garden, orchard, etc. That night I was again assailed, and in the morning counted forty new hillocks of suffering on my chest and shoulders only. By the next evening, Monday, the number increased to seventy-four countable ones, besides many which were in such clusters as to be uncountable, and that on the neck, throat, arms, and shoulders only, a more than equal number being scattered about elsewhere, the nape of the neck being an especially crowded situation. I began to think that I had mistaken the cause of my suffering and that I must be the subject of some eruptive disease, but on taking a lens I saw that on every mound sat a scarlet-coated enemy. I have vainly tried to kill or dislodge them. I have put lumps of wet carbonate of ammonia on them, and drops of glycerine, but without success. I have tried to remove them with a fine needle, with scissors. I have attacked them 'tooth and nail,' in front and in rear, all alike in vain. The body of the insect moves backward and forward as you press it, but the head remains buried in the flesh and, as I believe, remains there till the animal dies—a deliverance which appears to occur about forty-eight hours after its first grip is taken."

Leptus autumnalis is the scientific name for what is popu-

larly known as the Harvest Mite or Harvest Bug. It is the larval form of *Trombidium holosericeum* (or *Tetra rhyncus* of others). In size it is one of the smallest of our tormentors, not, as one observer describes it; more than a hundredth part as big as a flea, and so minute that three or four might escape notice on the point of a needle.* In its larval state it is a hexapod, and is a parasite upon the harvest spider, with which it must not be confused. After its final moult and acquisition of another pair of legs, it leads a wandering life and preys upon other insects, such as aphides. It is zoologically one of the mites (*Acaria*), and more nearly allied to spiders than to insects. In its adult state it possesses four pairs of legs and a clothing of crimson silky hairs; but in its larval condition its colour may vary from green to red. This change is probably due to the imbibition of blood. According to some observers it embeds itself in the skin and is unable to extricate itself, and there dies. From the differing accounts which are given of it we may suspect that both in its larval and adult forms it attacks the human skin, and that the two have been confused. More exact observations on this point are to be desired. It is said to prefer wheatfields, but is common in some gardens and upon certain plants—beans, peas, and currant bushes. It is most active in August and September, and most abundant in hot summers. My correspondent is probably mistaken in supposing that he got it on the seashore. Even in localities where it most prevails it is supposed to be restricted to certain fields and gardens.

The rôle taken by Insects as vehicles of contagion assumes every year a more important position in the estimation of clinical observers. It is exceedingly probable that the common house-fly was the carrier of contagious material from wound to wound in the days when hospital gangrene prevailed in epidemics. The initial case was usually one of syphilitic phagedæna, and the flies did the rest. The same might not improbably be the case in many instances of hospital erysipelas. In purulent ophthalmia, as observed in hot climates and in the army, and to a less extent occa-

* J. E. Stephens in *Science Gossip*, 1877.

sionally in English practice, flies no doubt were the chief agents in its spreading. In the epidemics of school ophthalmia they are again to be suspected.

The spread of the ague germ by means of mosquitoes is now an established fact, but here we have an instance of the parasite breeding in the tissues of the insect, and not of its mere transference. The suggestion that mosquitoes are a means of contagion in leprosy has had its advocates. It is, however, I think, conclusively negatived by the fact that of the European immigrants into leprosy districts scarcely any contract the disease.

As regards the spread of syphilis, it is not impossible that house-flies having access to secondary sores might transfer the poison, say, to the eyelid or lip of another person. I have never seen a case in which such transference was suggested, but many in which no more plausible explanation was forthcoming. Not once in ten cases in which a chancre occurs on some part of the naked skin of the face or body is the patient able to give any guess as to the source of contagion, and it may be that not a few of these are caused by insects. In two instances which have come under my own observation fleas have been definitely suspected. In one of these the evidence was strong, but in the other less so. Both occurred to medical men. In one the patient was a married, more than middle-aged man. He came to me with a well-characterised secondary eruption. He assured me that there had been no sexual exposure to risk, and he allowed a careful examination. He showed me a dusky papule on one leg which he said was his original sore, and which he traced to a flea-bite received in an omnibus. The flea-bite was recognised at the time, and the spot became irritable some weeks later and remained so through the secondary stage. In the second case, of which a young surgeon resident in a hospital was the subject, I did not see the case so early, and had only my patient's assurance that he had never had a primary sore anywhere and had never encountered any sexual exposure. He remembered, however, having had a long persistently irritable flea-bite on one forearm. This had disappeared when I saw him, and there was no trace of

chancre on the genitals. When we reflect upon the exceedingly minute quantity of lymph needed to convey syphilis (as shown in vaccination cases), there does not appear to be anything improbable in the supposition that fleas rapidly passing from the skin of a syphilitic to that of a healthy person may be the means of conveying contagion.

It is desirable in reference to all the diseases of the skin which appear to originate and spread not from any blood condition, but wholly on the surface, to remember that insects may be agents in the process. Such agency may in some cases be direct—that is, by the transference of specific germ matter—or it may be indirect by originating an inflammatory process favourable to the development of germ matter already present in a latent condition. These questions are of especial interest in respect to such diseases as lupus vulgaris, which we are obliged to regard as a form of tuberculosis of the skin. This malady usually begins as a single patch and often remains so, but in many other cases numerous patches scattered irregularly over limbs, face, and trunk make their appearance almost simultaneously. Under such circumstances they are never arranged with bilateral symmetry, as are all blood-produced eruptions, and we can only suspect either external inoculation or transference through lymph channels. The great distances which often occur between the patches when there are only a few somewhat discredits the latter hypothesis. I dare not do more than just remark that if we might suppose that the multiple patches had been located by the bites of fleas or mosquitoes the facts would be very fairly met. The reader who wishes for an illustration of what is here meant may suitably recur to the narrative of the boy L—— N——ns, recorded in Vol. IV. and illustrated by a series of drawings in the museum. See ARCHIVES, Vol. IV., and also "Smaller Atlas," Plates 67, 68, and 76, 77.

It is not necessary to assert that the flea or other insect actually transfers the tubercle bacillus to the spot bitten. It may be that a process of chronic inflammation originated in the tissues of a tuberculous subject is sufficient for the production of a local patch of lupus. The observed fact that

local inflammation (not to be diagnosed) usually precedes characteristic lupus-changes favours this latter hypothesis.

It evidently gives the scientific entomologist much satisfaction to correct the blunder of the unscientific reader, and to assure him that a "gnat" and a "mosquito" are the same thing. Yet the assertion is true only in a sense. If we take the term "gnat" to imply any member of the *Culex* family and "mosquito" to mean, in its original sense, a minute fly that bites, then undoubtedly gnats are mosquitoes. It remains true, however, that there are thirty-five species of gnats in Europe, and one hundred and thirty in the rest of the world, and that these differ in size and in their capacity for causing irritation on the human skin. We may understand, therefore, that whilst the family of "gnats" is identical with the family of "mosquitoes," there may be great differences between individuals of different species, and that what we know as "a mosquito" in the tropics may be very different from any one of our English gnats. To imply, therefore, that any given mosquito and any given gnat are identical is so far from the truth that it is very misleading. The popular creed that mosquitoes are species of gnats, possessing especial potency for irritation, is after all a very fair expression of the facts. Even in England there are some gnats which are bigger and more exasperating than others, and one, the *Culex annulatus*, which sometimes emulates the habits of the mosquito, and betakes itself to houses and bedrooms. Most English gnats, as is well known, prefer to remain in the open air, and only trouble those who go into their midst.

All gnats and all mosquitoes belong to the Dipterous family Culicidæ. In all it is the female only which sucks blood; none have stings, and for all the presence of water is necessary in their early stages of life, their eggs being always deposited on the surface of a pond or ditch in which the larva is destined to live.

The problem to which recent investigation has been directed in reference to the malarial infection, has been to determine which particular gnat or mosquito it is which carries it, or whether there are several, and this Dr. Ross and his coadjutors believe that they have solved.

Fleas zoologically are insects of the Dipterous order (flies), but have lost their wings. In their larval stage they are not blood suckers, but live on particles of organic matter found in the dust. They may thus breed in the floors, &c., of inhabited houses. Most mammals and many birds have their own appropriate flea, but a certain interchange of host is often practised.

The Chigoe (*Sarcopsyllus penetrans*), or Jigger of the tropics, is a flea the female of which burrows under the skin to deposit eggs. They do not hop about like English fleas, but fix themselves to the skin, and are most difficult to remove.

Many years ago, on a hot summer day, I allowed a gadfly, which had settled on a finger, to take his fill. It occupied him several minutes. The site of his puncture developed a little, firm papule, which was very irritable for a week or two. It then almost wholly disappeared, but a few weeks later again became very irritable, and again became hard. It was six weeks at least before I finally got rid of the papule, and for much longer I could easily recognise its site.

When I first came to London as a student, for a year or more I imagined myself the subject of urticaria, being liable occasionally to crops of large and very irritable wheals. Finally, I obtained irrefutable evidence that these wheals were nothing but flea-bites. I have since then seen many patients in a like predicament, and some who had taken much longer to make the discovery. In particular I remember the case of a barrister who used to go on circuit, and who always got "nettlerash" in certain cities. I succeeded in convincing him that what he really got was flea-bites.

That flea-bites (or in some cases *lice*-bites) are the real cause of what is known as urticaria pigmentosa I have long held. I have tried also to teach it, though I fear with but small success. The love of "morbid entities," the preference for mysterious causation, and the satisfaction conferred by a nominal diagnosis constitute together a phalanx of prejudice which to many minds renders unaccept-

able the suggestion of such a simple explanation. I feel, nevertheless, quite sure that it is the true one.

The common bed bug is one of a large family of "Bugs," some of which live in water and some on land. They belong to the Heteropterous division of Rynchota. All Rynchota, as the name implies, possess a beak or rostrum, which in many is specially adapted for piercing and sucking. This beak consists chiefly of the lower lip, which has become elongated and divided by three or four joints, and possesses a groove on its upper surface. "This groove forms a sort of sheath, in which are lodged four long slender blades corresponding to the mandibles and maxillæ of other insects, but here transformed into piercing organs. These parts are covered above by the narrow but slightly elongated upper lip." Thus the whole tribe of "Bugs" have a mouth adapted not for eating but for sucking the juices, either of plants or animals. Most bugs have a disagreeable odour, which arises from a liquid secreted by special glands in the abdomen. The common bed bug, which attacks the human species (*Cimex lectularius*), is a wingless insect, and with antennæ having four joints, and a beak of four joints. The beak can be turned back to lie in a groove under the throat. Mr. R. I. Pocock, who writes the article on Insects in the "Royal Natural History," and from whom I have quoted, informs us that closely allied species are found in dovecotes and in the nests of martens and bats.

The bug is believed to have been rare in England until within the last two centuries, and it is still confined almost wholly to cities, and in them to the homes of the poor or to those where lodgers are received. It is not very difficult of extermination.

The female deposits her eggs early in summer, and usually in crevices of wood or behind wallpaper. They are of large size compared to that of the mother. They usually hatch out in about three weeks. The larva resembles the perfect insect, excepting in size and colour, and after several moultings attains its perfect development in about eleven weeks.

The habits of the bug are not known with much exactitude, for although not uncommon, it is regarded with so

much disgust that it is but seldom made the subject of careful investigation. It is in the main nocturnal in its attacks, and confined to the neighbourhood of beds, but it may certainly harbour in woollen clothes, and is often seen in daylight. The effect of its punctures would appear to vary very much in different persons. It is not improbable that the tissues of those who are much exposed to its attacks soon become tolerant. We know of no persisting or even common eruptions which are attributed to bug-bites, and amongst those who for the most part live in infested houses not even the most temporary ill results are witnessed. It is quite otherwise with fleas and lice. In the case of strangers, however, bugs often produce eruptions of almost alarming aspect. Whilst fleas usually cause an urticarious wheal with raised and abruptly margined borders, the area of inflammation caused by a bug is more often a dusky swelling, highest in the centre, and ill defined at its edges. It is not in the least like an urticaria wheal, but is puffy-looking, and seldom round. The face is the part most often attacked, or, in bald persons, the scalp. In the middle of the patch the site of puncture may usually be identified. It is necessary for the surgeon to be familiar with the aspect of bug-bites, or serious mistakes in diagnosis may be made. The inexperienced not unfrequently seek advice concerning them. As a rule the number of papules produced in a single night is not great, and they are almost always grouped. The grouping, as in the case of other insect parasites, is always peculiar. Often they are confined to one side of the body and to one region, but if more general they are never arranged with symmetry, but usually constellation-wise; that is, in lines at angles to each other, or quite irregularly.

I have repeatedly been consulted by elderly gentlemen with bug-bites on the bald scalp, and sometimes by younger persons, or for children, with them on the covered parts of the trunk or limbs. The last case which I have seen was in a young lady who had long been under my care for lupus erythematosus. She came in great alarm because the eruption was, as she thought, appearing on her chest, and showed me a large group of a dozen or more dusky papules

under her right clavicle. They were almost of plum colour, and some of them half an inch across. All had appeared in a single night, and in some the puncture was easily visible.

I do not know of any observations as to the length of time which the erythematous swelling caused by a bug-bite may last, nor whether they are liable to any recurrent irritation. Although bugs do not in any sense sting, but only pierce and suck blood, yet it is quite possible that the foetid secretion which characterises them may in some instances find access to the puncture and cause irritation. The glands which secrete it are on the abdomen of the insect. The presence or absence of this secretion may perhaps explain the production or otherwise of the swelling, which appears to vary so much in amount in different persons, and perhaps in the same person at different times. I have not been able to find any information as to whether these glands are peculiar to either sex.

True lice are now recognised by naturalists as insects which have become degraded by parasitic habits. They belong to the order Rhyncota, but have lost their wings. The head of a louse carries short cylindrical antennæ, which are usually five-jointed. The mouth consists externally of a soft retractile beak, somewhat conical in shape, and furnished below with a row of hooks for attachment. Within the fleshy beak there are four grooved pieces, forming by their juxtaposition an inner membranous tube which can be extended beyond its sheath, and acts both as a piercing organ and as a conduit for the passage of the blood which is sucked up by the insect. The thorax is small, and not distinctly divided into segments, while the abdomen is relatively large, generally somewhat elliptical in outline, and exhibits seven or eight clearly marked segments. The tarsi are two-jointed, with the second joint in the form of a claw, which can be turned back on the first.

THERAPEUTICS.

Mr. Teale on Ether as an Anæsthetic.

Mr. T. P. Teale has kindly sent me a reprint of his article on Ether contributed to the "Encyclopædia Medica." With Mr. Teale, I myself learnt the use of ether in 1873 from Dr. Joy Jeffries, of Boston, who was then in England, and an enthusiastic advocate for ether in preference to chloroform. Like Mr. Teale I was a convert, and like him have used it ever since, and have strongly urged its advantages. In my own practice I had lost one patient from chloroform (an excision of the elbow) and only one, but I had been the witness of several other deaths, and in my capacity as Hospital Reporter and Editor had chronicled many, and carefully examined their facts. I had also in my own practice had several which were saved with difficulty. Since the use of ether I have never had even a case of serious alarm. In this latter point, although he does not expressly say so, I believe that Mr. Teale's experience has been parallel with my own.

Mr. Teale's paper is full of sound practical suggestions, as is all that comes from his pen. In one or two minor points my practice has differed from his, but in most of what he writes I heartily concur. We differ as to whether it is ever wise to give chloroform as introductory to ether. Mr. Teale would do this in certain exceptional cases, as for instance to overcome fear in young or very timid persons. My impression is that so doing is to court a definite risk, for it is precisely in very nervous persons and in the beginning of the inhalation that danger is often encountered. It was in just such a case that my own fatality occurred.

If a patient is unusually nervous a little brandy is a good preliminary, or gas may be used, or a few whiffs with the ether inhaler held at a distance, but on no account would I begin with chloroform. On the other hand I have not unfrequently employed chloroform after partial insensibility had been secured by ether, and have never under such circumstances had any anxiety as to heart-failure. Mr. Teale thinks it very dangerous to give chloroform in order to conquer the patients' struggles induced by ether. In this he may be right, for it is always dangerous to push chloroform during violent struggling, but I cannot believe that the preliminary use of ether in the least increases the risk. The only conditions under which Mr. Teale allows

chloroform to follow ether is in operations on the face or mouth, in which the ether inhaler cannot be used. Most surgeons will agree with him that under such circumstances a very small quantity of chloroform will usually suffice to maintain quiet.

The form of inhaler used by Mr. Teale is the original "Clover." To defects in the making of this instrument he attributes much of the prejudice which still exists to ether, and more especially the belief that its administration is difficult. For myself I have always kept to a very simple form of mask containing a sponge. Dr. Jeffries and the Bostonians used only a towel folded to form a cone. In the mask which I use a towel, with a large sponge inside it, is pushed into a leather cap. The cap is perforated at its top to admit air, and there is a large hole to allow of the pouring in of ether from above. The overlapping

borders of the towel are to be carefully spread out over the patient's face, and held by the operator's hands, one on each side, the whole thus being kept in place. Thus held the patient may struggle, or even rise up, there is no displacement of the apparatus, which from first to last should never be lifted from the face until full insensibility is produced. Rarely more than four to six minutes will be required. The apparatus is, I confess, wasteful of ether, but that is its only disadvantage. It is safe and efficient, and needs only courage in its use. Once applied, it must not for a moment be displaced.

The Abortive Treatment of Gonorrhœa.

(A CONVERSATION.)

Ille. From prescriptions which you have given to patients of mine, I infer that you use astringent injections in all stages of gonorrhœa.

Ego. I do so; but I would rather call them parasiticide injections. My aim is to destroy the contagious elements as promptly as possible.

I. But do you not think the injections, whether we call them astringent or parasiticide, are very risky in the acute stage?

E. Were your patients made the worse by them?

I. No, I must admit they were cured without drawback. For all that, I dare not order such remedies in the early stages of gonorrhœa. I should expect orchitis or urethral abscess, or prostatitis, or some other dreadful complication, and stricture to follow.

E. My theory is that all the complications of gonorrhœa are best prevented by promptly curing the original disease, and that they result from its neglect. So I always attempt not a palliative but a suppressive treatment. It is the case in which a gonorrhœa is allowed to run on into a chronic stage which ends in strictures.

I. May I ask what astringents or parasiticides you usually employ?

E. I have but one, the chloride of zinc. I learned its use near fifty years ago, when I was surgeon to the Metropolitan Free Hospital, and I have used it ever since.

I. Do you think it superior to the sulpho-carbolate?

E. Really I have no experience of that or of any other. I know that the chloride will cure and I keep to it. It saves an immense deal of trouble to have a remedy which you can trust.

I. What, then, do you do with intractable cases?

E. They are few and far between, and usually what they get is an increase in the strength of the injection, instructions to use it more frequently, or it may be simply an exhortation to patience and perseverance. You remember the story of Brindley, the canal engineer?

I. No.

E. Brindley's method of constructing canals was to puddle their bottoms and sides with clay. On his death-bed his advice was sought by some friends as to a canal which would not hold water. "Puddle it," whispered Brindley. "We have puddled it," they replied. "Then puddle it again," was the answer. That I may confess is pretty much my position in reference to the chloride of zinc for gonorrhœa.

I. I am bound to admit that one of my patients, for whom I had tried almost everything, was cured very quickly by the prescription you gave him. His, however, was a chronic case. I should still fear to prescribe chloride of zinc in an early stage.

E. The very name of chloride of zinc is, I find, alarming to many; they fancy that it is a caustic, and forget that it may be diluted. Just in the same way many regard tartrised antimony as a depressant and mercury as a poison, forgetting that everything depends upon the dose. The prejudices, not only of the public, but of our own profession are innumerable.

I. I believe, however, that the strength of your chloride of zinc solution is considerable?

E. It is almost invariably two grains to the ounce, sometimes as weak as one grain, and sometimes as strong as

three. These limits I never exceed, and in ninety-nine cases out of the hundred it is two grains.

I. Again I say I dare not give a patient with acute gonorrhœa an injection of two grains to the ounce of chloride of zinc. I should expect all sorts of catastrophes. Yet I believe you do not even confine your patients to the house?

E. No, scarcely ever; but I will tell you what I do do, I give them all purgatives and bromide of potassium, and insist upon a low diet. These accessories I regard as most important parts of the abortive treatment. In very severe cases where the penis is much inflamed, I even give tartar-emetic and push it to nausea.

I. And still do not confine your patient to bed?

E. Not necessarily. If he is very sick he will usually have sense enough to go to bed.

I. Do you not think that the use of injections causes risk of orchitis?

E. By no means; it prevents it. Orchitis depends upon the extension of the gonorrhœal inflammation to the ejaculatory duct and along the vas deferens. It is a mere superstition to imagine that it is "sympathetic" with the urethra, and a mere prejudice to imagine that injections can cause it. It is part of the gonorrhœal attack, and is to be prevented by curing the gonorrhœa.

I. But may not the injection carry the virus down the urethra?

E. Not until it has first disinfected it. There are, besides, certain precautions to be observed in this matter. The patient should be instructed before injection to first void his urine, and secondly to inject warm water and let it run out, and lastly to use the solution. Theoretically it might perhaps be better to omit the warm water for fear of carrying the discharge backwards, but in practice I have not found any inconvenience. Cases of orchitis in patients under treatment have in my practice been infinitely rare.

I. In reference now to gonorrhœal rheumatism, do you not think that the abortive treatment, drying up the discharge, gives increased risk of it?

E. No; it tends, I believe, to prevent it. In all stages and under all conditions kill the gonococcus, and stop the urethritis which it causes, as quickly and as completely as you can. Gonorrhœal rheumatism occurs in my experience almost solely in persons of a distinctly arthritic diathesis, and for the most part in those who directly inherit gout. Its exciting cause is, however, the absorption into the blood of elements derived from the inflamed urethra, possibly the gonococcus itself. To prevent it, cure the urethral inflammation. If it have already set in, still cure the urethral inflammation, and thus cut off the supply of irritating material.

I. Does not your two-grain solution of the chloride of zinc cause a good deal of pain?

E. It causes smarting the first few days, but after a little time scarcely any. All urethras bear it well. It is in reality a weak solution. My confidence in it and in its harmlessness was partly obtained in eye practice. It is I believe, by far the best remedy for purulent ophthalmia, whether in the infant or adult, and may be used freely.

I. Do you advise a two-grain to the ounce solution of the chloride of zinc in the early stages of ophthalmia neonatorum?

E. Yes; and the earlier it is begun the safer for the eye. It will never do any harm, and the more promptly you cure the better. It is the timorous neglect of efficient treatment which is dangerous.

MISCELLANEOUS.

No. CCCXLV.—*Petrarch on Medical Topics.*

The subjoined extracts from Mrs. Dobson's *Life of Petrarch* contain references to medical or pathological matters which may possibly be of interest to some of my readers. Petrarch had himself paid much attention to matters of diet, etc. He had many medical friends, but was always a very reluctant and sceptical patient.

“ ‘ 1350.—While I was full of these thoughts, the horse of the old abbe, which was on my left side, going to kick at mine, struck my leg just under the knee: the stroke was so violent that it sounded like bones snapping asunder, and drew all our party round me. I felt extreme pain: but not daring to stop in so solitary a place, I made a virtue of necessity, got late to Viterbe, and was dragged to Rome by the aid of my friends. As soon as I got there I sent for the physicians, who having examined my wound, found the bone laid open, and the iron of the horse's shoe had left a mark on it. The smell of this neglected wound was so strong that I could scarcely bear it; though our familiarity with, and affection for ourselves, renders many things supportable we could not bear in others. How vile and abject is man, said I, if he does not compensate for the weakness of his body by the strength of his mind! The days I was obliged to pass wholly in bed appeared longer here than elsewhere.’ ”

“ In October, 1354, Petrarch lost a friend, whose bounty and favor towards him had sincerely attached his heart; this was John Viscomti. He had a small lump on his forehead, just above his eye-brow: he had it cut off, and died in the night, without having time to receive the sacraments.”

“ The month of September was always critical to Petrarch; he generally suffered in this season from a tertian fever. ‘I

was obliged,' says he, 'the fits were so violent, to pass the whole of the month in bed. Had it lasted much longer, it must have outlived me.'"

"Petrarch had an inflammation in his leg while he was at Linterno, occasioned by a large volume of Cicero's epistles falling on it as he was reaching it down, and this happened more than once. 'I could not help,' says he, 'asking Cicero, with a smile, Why do you strike the man who loves you so much?' His leg was so bad through neglect, that advice was sent for, and the physicians thought it must be cut off; but by rest and fomentations he recovered."

"1359.—The air of Milan was become infectious. 'Come hither,' says Albin; 'the air is very good, and you will have always near you a physician and a friend.' Petrarch replied, 'It becomes not one of my age to fly from death: it is needless so to do, because it comes every where. I would sooner visit you as my friend than my physician. The art of physic may be useful to preserve health, and cure lesser disorders, but in violent diseases it is of little use. We see physicians themselves despair, and run away, which proves the ignorance or the weakness of men.'" This was written during prevalence of the plague.

No. CCCXLVI.—*A Physician's Dress when visiting Plague Patients.*

I am indebted to Dr. Ludwig (at present resident in Venice) for a drawing from which the appended woodcut is taken. It is copied from a manuscript work dating about 1750, preserved in the Library of the Museo Correr in Venice (MSS. Gradenigo—*Dolfin gli abiti dei Veneziani*). The illustrations are in water colours by Grevembroek. The precise source from which this artist borrowed this subject has not been ascertained. The figure represented is that of a physician equipped for visiting patients ill with the plague. He is enwrapped in a habit which completely protects his body and he wears a mask for his face. The mask has a

nose of enormous length destined to contain odoriferous substances supposed to be disinfectant. The following extract is the description given in the work just quoted:—

“Medico industrioso—I medici ed i Chirurghi in tempo di peste adopravano una veste sola, tutta chiusa, e liscia di puro lino ben profumata con bacche di ginepro, secondo che quivi sta disegnato il modello. Può darsi, che fosse di tela cerata per meno soggiacere a qualsisia esa-



lazione maligna, e se bene la figura delineata dal Bartolini mostra la manica larga nella sua estremità. Noi giudichiamo, che fosse ristretta e benissimo unita al braccio, e forse con li guanti. In aggiunta all'abito ponevano al volto una maschera, intinta nella cera che copriva tutto il viso, ed il capo, con nascaondere i capelli, acciò non s'imbevessero di quei miasmi pericolosi, e si difendevano gli occhi con gli occhiali ed il naso, con un rostro adunco in forma che restasse luogo al respiro riempendo quel vano di odori alessifarmaci e grati. Benchè a prima vista riuscisse la moda ridicola, non fu discaro però assicurarne allora a costo di un poco di riso la propria e l'altrui salute. Per altro del, 1478, comandò il maggior Consiglio a 16^a luglio, che fosse e seguita la seguente legge. Medici in tempore pestis de Venetiis non discedenti.”

No. CCCXLVII.—*Cowper on Medical Topics.*

The following extracts from the charming correspondence of the poet Cowper have some interest for medical readers. The first three may be allowed to convey a warning against the giving of a too confident prognosis especially of ill. It is a warning which some in the present day will do well to take note of :

“Mr. Perry will leave none such behind him. He is dying, as I suppose you have heard. Dr. Kerr, who, I think, has visited him twice or thrice, desired at his last visit to be no more sent for. He pronounced his case hopeless ; for that his thigh and leg must mortify. He is, however, in a most comfortable frame of mind. So long as he thought it possible that he might recover, he was much occupied with a review of his ministry.”

“On Thursday Mr. R—— was with him again ; and at that time Mr. Perry knew that he must die.”

“In my last I wrote you word that Mr. Perry was given over by his friends, and pronounced a dead man by his physician. Just when I had reached the end of the foregoing paragraph, he came in. His errand hither was to bring me two letters.”

The following refers to his own eyes. Cowper had suffered severely in boyhood from ophthalmia, probably of the pustular and strumous form, and had resided for a long period in the house of a London oculist for treatment. It was before the days of Pagenstecher's ointment, and the cure was very tedious. The eyes were irritable ever afterwards. There was gout in the family :

“My silence has been occasioned by a malady to which I have all my life been subject—an inflammation of the eyes. The last sudden change of weather, from excessive heat to a wintry degree of cold, occasioned it, and at the same time gave me a pinch of the rheumatic kind ; from both which disorders I have but just recovered.”

The next extracts describe clearly an impacted fracture of the neck of the femur. Mrs. Unwin was elderly. Had she lived in the present day, she might perhaps have been put under an anæsthetic for the purpose of examination,

and possibly had the X rays used with the result of an exact diagnosis. As it was, she was probably better off in being allowed to remain in bed with the diagnosis of a bruise, unencumbered by any splint and exempt from injurious manipulation. It is not always for the patient's good to insist on precise knowledge.

"I have more items than one by which to remember the late frost: it has cost me the bitterest uneasiness. Mrs. Unwin got a fall on the gravel-walk covered with ice, which has confined her to an upper chamber ever since. She neither broke nor dislocated any bones, but received such a contusion below the hip as crippled her completely. She now begins to recover, after having been helpless as a child for a whole fortnight; but so slowly at present, that her amendment is even now almost imperceptible."

"Mrs. Unwin, though two months ago she fell, is still lame. The severity of the season, which has not suffered her to exercise herself in the open air, has, no doubt, retarded her recovery; but she recovers, though even more slowly than she walks."

My last quotation would seem almost to imply an anticipation of discoveries which we have believed to be quite modern.

"I did not know, or even suspect, that when I received your last messenger, I received so eminent a disciple of Hippocrates; a physician of such absolute control over disease and the human constitution, as to be able to put a pestilence into his pocket, confine it there, and to let it loose at his pleasure. We are much indebted to him that he did not give us here a stroke of his ability."

No. CCCXLVIII.—*Small-Pox as a Factor in History.*

"St. John, on the 20th of April, brought down another Message from the Queen, referring to an event of grave concern which had just been announced from Germany. The Emperor Joseph was not yet thirty-three years of age. He had a strong constitution, and might expect a long life. But he was struck down by a malady so frequently fatal in that age, the small-pox, which in this same month carried off the

Dauphin, only son of Louis the Fourteenth. Joseph expired at Vienna on the 17th of April, New Style, leaving no male issue behind him." Earl Stanhope's (Lord Mahon) History, vol. viii., page 480.

It was the death of Joseph of Austria which indirectly led to the disgraceful peace of Utrecht and altered the destinies of Spain, and it was the death of the Dauphin, which — introducing the long reign of the weak and profligate Louis XV.—probably conduced to the French Revolution.

No. CCCXLIX.—*An Autopsy in the Seventeenth Century.*

Henry, Prince of Wales, son of James I., died after a short illness at the age of nineteen. He had enemies, and poison was suspected. The court physicians certified after an autopsy "that his liver was paler than ordinary, his gall without any choler in it, his spleen, midriff, and lungs very black, and his head full of blood in some places and in others of water" (Echards' "History of England," p. 388).

No. CCCL.—*Various Items.*

In the Pottos (a race of slow lemurs found in West Africa), the index finger consists only of a stump without distinct joints, and not provided with a nail. They have short tails ("Royal Natural History," vol. i., p. 233).

The Kaffirs suffer much from scabies. It is said to affect their bodies more than their hands. Is not often communicated to Europeans.

Columbus is reputed to have suffered much from gout.

Those who are so fond of suspecting syphilis as the cause of infant mortality may be reminded that John Colet was at the age of thirty the only surviving child out of twenty-two.

Not only was his mother *insigni pietate mulier*, but yet more conclusive, she bore and lost her children before the introduction of syphilis into England (last quarter of fifteenth century).

Wiseman who wrote 1660 (*circ.*) has the statement: "Though brought to their ends by some other apparent disease, yet the *pox* hath been judged the foundation." Here we have a distinct recognition of the remote forms of tertiary disease, and perhaps of the *para syphilitica* of Fournier. It is also perhaps one of the earliest instances of the use by a surgeon of the word "pox" as being an exact English equivalent for syphilis. It had been long employed for other eruptions in spelling of "pocks." In the sixteenth century Queen Mary of Scotland is reputed to have spoken contemptuously of "a pocken priest."

No. CCCLI.—*Tuskless Elephants.*

The Amsterdam Zoological Gardens had, when I visited them in October, 1894, three elephants, all Indian. Two of them (females) had no visible tusks, the third, a male, had very poor ones. Yet in the museum of the same institution I found five elephants' skulls, and although in all the tusks had been removed, yet in every one the sockets for them were present. In one of these the sockets were so small as to admit only three fingers.

In a beautiful zoological picture by Hondekoeter in the Hague Gallery, an elephant is represented. It is an Indian one and wholly tuskless. This is possibly one of the earliest paintings of the elephant made in northern Europe. A number of other foreign animals are well represented, evidently from some menagery of the time. (Hondekoeter died 1695.)

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